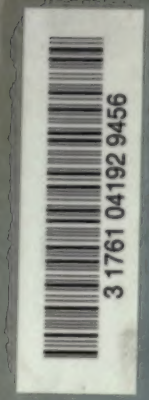

Hospitals and Dispensaries

PART TEN

Cleveland Hospital and
Health Survey

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Preface

The Hospital and Health Survey of Cleveland was made at the request of the Cleveland Hospital Council.

The Survey Committee appointed to be directly responsible for the work and through whose hands this report has been received for publication consisted of the following:

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The expenses of the Survey and of the publication of the report have been met by appropriations received from the Community Chest, through the Welfare Federation, of which the Hospital Council is a member.

The report as a whole, or by sections, can be obtained from the Cleveland Hospital Council. A list of the parts will be found in the back of this volume, together with prices.

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Hospitals and Dispensaries*

By Michael M. Davis, Jr., Ph. D.

I. The Care of the Sick

RESOURCES FOR CARE

NO thorough understanding of the work and problems of the hospitals and dispensaries of Cleveland can be had without seeing these institutions in a broad perspective. The primary purpose which leads to the establishment of hospitals and dispensaries is to provide care in illness. We need to understand not only what hospitals and dispensaries do for their patients, but also their relations to the community, and the part which they should play in the life of the average family.

The volumes of the Cleveland Hospital and Health Survey which precede this, in the Survey's series of publications, have been devoted to general community problems and to public health programs. As Dr. Haven Emerson, Director of the Survey, says: "First comes the description of the environment of the community; then its efforts at self-protection against disease. Then we must logically put education before practice; and, as the climax of the whole, the most elaborate, the most intricate, the most difficult of all medical social undertakings, the Hospital and the Dispensary, to show how a community does or can take care of those whom it has failed to protect."

The great emergencies which strike the life of the average family are sickness, accident, and unemployment. Sickness and accident both affect the physical welfare of the body, varying from the most trivial illness to the gravest emergency. The resources for dealing with sickness and accident vary accordingly, from the application of the simplest home remedies to the tense dramas of the operating table.

Studies of sickness made by the Metropolitan Life Insurance Company among its industrial policy holders, and by other agencies, indicate that from two to three per cent. of the population of a city like Cleveland are usually sick at any one time. This excludes minor illness and diseases not causing incapacity. In greater Cleveland this means that 20,000 to 30,000 persons are usually to be found ill on any given day, the number of course showing a wide variation according to season and to other conditions like the widespread presence of epidemic disease. We know that the hospital population of Cleveland ranges from 2,000 to 3,000, being generally near 2,500. Thus about ten per cent. of the sickness in Cleveland, excluding "minor" ailments, is generally cared for in hospitals. These figures should help to put the hospital problem in its due perspective.

* The section of this report entitled "Some Practical Matters of Administration," is by Warren L. Babcock, M. D., Consultant in Hospital Administration for the Survey. Other contributions by Dr. Babcock are indicated in their places, and his helpful cooperation throughout is gratefully acknowledged. Mrs. Mary Strong Burns, R. N., is the author of the section on "The Convalescent and the Hospital," and Frederic Brush, M. D., of an important part of "Community Program for Convalescent Care." For the collection of much information utilized in the report the author is indebted to many of his colleagues in other branches of the Survey. Especial acknowledgment should be made of the studies contributed by Anna M. Richardson, M. D., and by Miss Harriet L. Leete, R. N.; and of the devoted, painstaking work of Miss Josephine Colegrove in the collation of data and the preparation of the manuscript for the printer.

We need to approach the study of the hospitals and dispensaries of a great city from the standpoint of the community rather than of the institution; to see them as the average citizen and the average family sees them, rather than as the physician or the specialist in hospital administration. Laying aside for the moment the demands which the average family may make on hospitals and dispensaries for the promotion of health, a real though slowly growing part of their function, the primary reason for the utilization of hospitals and dispensaries is the occurrence of sickness or accident. Whenever illness or accident comes, the individual or the family must reach a decision as to what is to be done. Choice must be made among possible resources. It is well to list these resources so that all of the elements of the picture shall be in mind. A list of ten resources for the care of illness might be included:

1. The home remedy,
2. The advice of friend, grandmother, or neighbor of reputed wisdom,
3. The private physician,
4. The drug store,
5. The physician of an organization of which the patient or family is a member (for instance, lodge doctor, industrial physician, city physician),
6. The quack doctor or medical institute,
7. The midwife (for obstetrical care),
8. The nurse,
9. The hospital,
10. The dispensary.

The attitude of a community towards its hospitals and dispensaries is made up of the points of view of its individual citizens. These points of view are practically expressed in determining what choice is made among the resources for the care of sickness. Such choice or decisions are influenced by considerations of finances, but also by custom, personal connections, prejudices and information or misinformation regarding the availability, powers and prestige of the various resources for the care of a given case of illness or accident.

It is obvious that the ten resources for the care of illness vary in their grade of efficiency. It is obvious that the various elements in the population select resources differently. Thus the use of the midwife is largely confined to foreigners; the quack reaps his richest harvest from among the less educated; the service of the dispensary at the present time is chiefly for those of limited means. One man with a pain in his back goes to a dispensary. Another equally unblessed with this world's goods hies himself to a drug store and purchases and applies a widely advertised "Rheumatic's Ready Relief." One woman goes to a hospital for an operation; her neighbor two blocks away refuses to go to an institution even on the advice of her

family physician, because she is "afraid of hospitals." A member of a lodge utilizes the services of the official doctor of the organization during a minor illness, but when he thinks something serious is the matter with him, he calls a "real doctor," meaning one whom he pays. Quacks' offices are thronged with thousands of credulous victims, and the mails are filled with money directed toward the coffers of patent medicine vendors. Choices among the resources available for the care of sickness are as varied as the circumstances surrounding each case, and as manifold as human nature itself.

A health survey of Cleveland might theoretically arrange the ten resources for the care of illness in the order of their relative efficiency, and then study, for different sections of the population, their usual order of utilization for different kinds of sickness or accident. Such a study cannot practically be made, but supposing for the sake of argument that it could be made, let us ask this question: would the order of utilization by the people of the ten resources for the care of illness correspond to their order of relative efficiency? In so far as it does not, the well-being of the community suffers. Reputable physicians and the hospitals and dispensaries in which these physicians render service, obviously constitute the primary and fundamental medical resources for the care of illness and the promotion of health. Are they used with the degree of fullness and of discrimination with which they should be? If not, why not? The answer would not be the same for all groups of the population.

A study of the hospitals and dispensaries of Cleveland cannot rightly be limited to the amount and the nature of the work done, the internal administration, and other technical problems, important as these are. It needs also to include a study of the attitude of different sections of the people—the medical profession, the well-to-do, the poor, the foreign-born, etc. toward these institutions. It is on the basis of these attitudes, understandings or misunderstandings, that the choice among medical resources is made in time of sickness or accident, and upon which the utilization of hospital and dispensary for the benefit of the public ultimately rests. Financial support of hospitals and dispensaries by the community depends precisely on the same considerations. In this section of the report of the Cleveland Hospital and Health Survey, therefore, an endeavor will be made to review the details of the work of the hospitals and dispensaries of the city, in their medical, administrative and financial aspects, and to consider also the relation of these institutions to the various sections of the public which use them or need to use them. Hospitals and dispensaries represent or ought to represent the organization of medical services upon a scientific basis, bringing to bear upon the needs of the individual patient the maximum resources in equipment and skill that twentieth century medical science can muster. To promote a better understanding of hospitals and dispensaries by the community is to promote at the same time their better and more discriminating utilization, and their more effective and generous support.

SOME DEFINITIONS

The hospital and the dispensary, taken together, comprise what may be called the organized or institutional practice of medicine. In the private practice of a physician, some patients are seen in his office, others in bed in their own homes or in a private room of an institution. In the institutional practice of medicine the dispensary patients correspond to those who are seen in the physician's office, and the hospital patients to those whom he sees in bed.

During the winter of 1919 and spring of 1920, when the Survey was made, there were 47 institutions known as hospitals, and 26 dispensaries and health centers in Cleveland and Lakewood. Under a law of Ohio which became effective in 1919, all hospitals and dispensaries must be registered with the State Department of Health and render to it an annual report. Eight of the above 47 "hospitals" had not registered with the State Department of Health at the time the field work of the Survey was completed (June, 1920). Their names were found in the telephone directory. They are not further referred to in this report, except in relation to the public supervision of hospitals, in the section on "Organization to Carry Out Plans." The definition of dispensary as thus far interpreted by the State Department of Health does not appear to include the Health Centers or clinics doing primarily preventive work.

The medical institutions of Cleveland may be further divided according as they are members of the Cleveland Hospital Council or not. Table I. in the Appendix gives the hospitals and dispensaries of Cleveland, stating after each the approximate number of beds in the hospital, and the approximate number of annual visits by patients to the dispensary.

On the accompanying map these institutions are shown in their proper location.

It is important to state certain definitions and distinctions which will be of service in understanding the problems and relations of the hospitals and dispensaries of Cleveland.

Hospitals may be broadly classified in two ways: first, according to the character of diseases treated, and, second, according to the relation of the institution to the community.

With regard to the character of diseases treated, the distinction is between general hospitals, such as City or Lakeside Hospitals, and special hospitals, such as Cleveland Maternity or St. Ann's Maternity Hospital. The latter receive only patients of a designated medical type. It will be observed at once that Cleveland has few of the second group.

On the other basis of classifying hospitals in their relation to the community, two divisions may be made:

(a) Public-service hospitals.

(b) Proprietary hospitals.

Fig. I.

Present and Proposed Location and Relative Size of Cleveland Hospitals

The first class receive patients as a public service, whether pay, part-pay or free patients. The second class are conducted as corporations for the profit of their owners. It is important to notice that the term "private hospital," which is not infrequently used, is decidedly ambiguous. The word "private" is sometimes employed to indicate a hospital supported by private funds as distinguished from a state or a municipal hospital. In another sense, a private hospital is taken to mean one which receives only private patients of certain physicians and no ward or "staff" patients. In still a third sense, the word "private" is applied to a hospital which is conducted as a private business for profit. To use the same word "private" for a hospital which is performing a great amount of public service rendered alike to those who pay and those who do not pay, as for an institution which is run as a business enterprise, involves dangerous confusion. The term "proprietary" makes the proper distinction.

This term, however, is not necessarily one of reproach. It is perfectly legitimate and proper for an individual or a corporation to maintain a hospital for profit, as a business enterprise. Such an institution corresponds to a "private school" or "academy," and may be as well conducted and as useful to a limited circle of patients as are many well known private schools to their clientele.

As will appear later, a number of institutions in the above list fall within the proprietary class. There are some of these hospitals which were incorporated as business organizations to be run for profit, but which in practice are conducted as public service institutions, and have been so recognized by the Cleveland Hospital Council. According to the principles which will be laid down in this report, the extent to which the public should assist financially in the maintenance of a hospital should vary in precise degree with the amount and proportion of public service rendered by the institution. To be able to measure this accurately and to make the results of this measurement known to the public or to the agency representing the public, such as the Community Fund, is one of the important aims which those interested in hospitals must have in view.

The degree of public service rendered by a hospital does not correspond with the number of its free patients. Some persons have the notion that doing charity means giving something for nothing. The twentieth century idea of charity is a service, not a dole. The public service rendered by a hospital should be measured from a financial standpoint by the amount of care given at a rate lower than the cost of the service. This in practice means measured by the number of days of care rendered during the course of a year. If a patient is treated for a day and pays only half the cost of the service, the hospital may be credited with one-half of a day's free care. Such is a simple method of estimating the financial aspect of the public service of a hospital.

From the professional standpoint, public service must be estimated in terms of kind and standard of care, a more technical and difficult matter to evaluate. Classification of hospitals according to the quality of service, an invidious task, can be undertaken here only with reference to one distinc-

tion. The public ought to understand the difference between the "medical boarding house" and the hospital.

In every large city are found institutions, usually of the proprietary class, which have an operating room, a nursing service, and which receive the patients of private physicians, put them to bed, nurse and feed them, and provide for nursing attendance at operation if the case is surgical. The private physician carries the same individual responsibility that he would if the patient were in bed at home. The difference is merely that there are facilities for a major operation close by, and that the patient's household is spared the difficulties of adjustment to illness, the introduction of a trained nurse, provision for a special diet, etc. These are to all intents and purposes medical boarding houses.

The modern hospital is as different from a medical boarding house as a passenger liner is from a tramp steamer. Both float and both will take one somewhere. But one is just a boat, while the other is a boat plus an organization.

The modern hospital provides the physician with certain facilities which are unavailable in the patient's home. Medical practice today requires more than the physician's individual trained senses. Laboratories for many tests and an X-Ray department are necessary adjuncts to modern medical practice. The patient cared for at home can secure these benefits only through expensive and somewhat slow recourse to private laboratories. In the hospital, this equipment and a vast variety of other instruments and apparatus are brought together under a single roof, and organized under a single control, so as to be most economically and effectively used. Modern medicine also is highly specialized. No one physician can master all the science. Many cases require examination and study by physicians each representing a different branch of medicine, in order that all the necessary facts be obtained, and through consultation an accurate diagnosis of the disease be established. The staff of a modern hospital provides a group of specialists working with joint equipment, and under a mutually acceptable plan of team work, which should render the service of each of maximum value to the others as well as to himself and to the patient.

Similarly the modern hospital provides assistants to the physician of special skill; the medical assistant, the interne; the laboratory assistant, the technician; the nurse, and the social worker. Through the aid of these assistants the highly special skill of the physician is kept for just that kind of work which requires it, and his time is not spent on routine or details. Consequently with a given expenditure of time and energy he can render service to a much larger number of patients, and more effective service at that.

A modern hospital may be defined as an institution in which there is joint use of medical equipment and cooperative organization of medical skill for the diagnosis, treatment and prevention of disease.

A critical study of hospitals makes it clear that some institutions maintain the principles of the medical boarding house with respect to their private

patients, while having a well organized system for modern hospital work with respect to their ward cases. Is privacy a substitute for service?

The distinction between the two types of services will be illustrated in numerous points during the course of this report, and will be of importance in connection with certain final conclusions. Each hospital trustee and every hospital patient will do well to see how these principles work out with regard to the hospital which he knows best.

The dispensaries may be classified as are the hospitals. As a matter of fact, the list of dispensaries on pages 984-986 contains none of the proprietary class. There are indeed some clinics maintained in Cleveland by individual physicians, whether on their own account or in connection with industrial establishments. Some of these are reputable enterprises; some of them are merely quack medical institutes. The latter class will be referred to only in connection with some general recommendations of the Survey in the section on "Organization to Carry Out Plans," as are the hospitals not registered with the State Department of Health.

Cleveland has only one dispensary treating the sick of the class confined to special diseases—the Babies' Dispensary. Its clientele is limited to children not over three years. A highly important group of special dispensaries, however, are the public health dispensaries, which aim to prevent rather than treat disease, to educate rather than to cure—the Health Centers, Baby Prophylactic Stations, and Prenatal Clinics. Broadly speaking, a line for the support of dispensary work is drawn by the municipal authorities on the border line between preventive and curative medicine; private support of dispensary work being largely though not wholly confined to the dispensaries treating the sick, and public support being almost entirely confined to the dispensaries whose work is primarily preventive and educational.

The term "dispensary" originally meant a place where medicine was given out or dispensed to the poor on the prescription of a physician, and the word has persisted, although at the present day the giving out of medicine is a minor function of a dispensary. Medical diagnosis, advice, and treatment other than medicine are the services of primary significance. The term "out-patient department" is frequently used as synonymous with dispensary when applied to a dispensary which is part of the organization of a hospital—the bed cases being the in-patient department and the dispensary the out-patient department. In this report, the term dispensary will be generally used except when it is desired to draw a special distinction between the "in" and the "out" patients.

The unit for measurement of the services rendered by hospitals and dispensaries is important to define. Hospital service is measured in days of care. A patient who has been in the hospital for two weeks has in this sense received fourteen units of service. The unit for measuring dispensary service is the visit paid by the patient to the clinic. It will be observed that the visits paid by patients to a dispensary in the course of a month or of a year is much more than the number of individuals treated, just as the number of days' care given patients in a hospital is much larger than the number of

different patients. In actually studying the work of a given institution or of the city as a whole, we are of course interested in the number of individuals cared for as well as in the bulk of service rendered. Days of hospital care and visits to dispensary clinics represent the latter element—bulk of work done. The number of individuals treated is in practice a more difficult figure to obtain, because of the likelihood of the same individual, in case of readmission to dispensary or hospital, being counted as a different patient.

One of the fundamental problems of every professional institution today is how to make a specialized and technical piece of work clear to the average person. The problem is to interpret hospitals and dispensaries to the community. This means stating facts showing the kind, amount and quality of service rendered, and stating them in such a way that they are easily understood by the average person. It is of relatively little importance what facts a temporary survey gathers and reports—such facts are at most only a cross-section, a momentary picture. It is of very great importance what facts the hospitals and dispensaries gather and present regularly to the public, and how they present them to the unprofessional mind—whether in a vivid and convincing fashion or in dry and technical form. What a board of trustees needs to know about their own hospital or dispensary; what the contributors to the Community Fund need to know about all hospitals and dispensaries; what the general public needs to know about the hospitals as a whole or about its municipal institution in particular—these are of fundamental importance for the Survey to suggest.

The cost of maintaining medical institutions has been increasing with great rapidity, not only because of the general rise in prices, but because of advance in medical science, the more elaborate equipment that is necessary, the higher specialization in many branches—in a word, higher standards of service, yielding better results for the cure and prevention of disease. Public comprehension of these new and higher standards has lagged behind their establishment in the strongest institutions. Such comprehension forms the basis on which taxes for municipal institutions must be levied and campaigns for community chests or for building funds successfully accomplished. Adequate moral and financial support of hospitals and dispensaries depends upon making these standards and needs clear in terms of human interest and popular understanding. The defining of units, the assembling of statistics and the compilation of professional reports are fundamental prerequisites. The statement and interpretation of these data to the community are a necessary sequence.

II. Hospitals

HOSPITAL PROVISIONS AND COMMUNITY NEEDS

Reserving the study of dispensaries for Chapter III., we may now compare the hospital facilities of Cleveland with those of other communities and with the probable needs of the city.

During the winter of 1920, while the Survey was in progress, the number of hospital beds in the cities of Cleveland and Lakewood was 3,378, including all the institutions registered with the State Department of Health.

Of these, 3,088 beds were in the 20 hospitals of the Cleveland Hospital Council, as follows:

	Beds
Cleveland City Hospital	785
Cleveland Maternity Hospital	60
Fairview Park Hospital	85
Glenville Hospital	74
Grace Hospital	35
Huron Road Hospital	84
Lakeside Hospital	289
Lakewood Hospital	53
Lutheran Hospital	50
Mount Sinai Hospital	225
Provident Hospital	29
Rainbow Hospital	85
St. Alexis Hospital	250
St. Ann's Maternity Hospital	55
St. Clair Hospital	43
St. John's Hospital	150
St. Luke's Hospital	139
St. Vincent's Charity Hospital	290
Warrensville Tuberculosis Sanatorium	270
Woman's Hospital	37
Total	3,088

The 11 non-council hospitals included 290 beds, as follows:

	Beds
Cleveland Emergency Hospital	22
Cleveland Home Hospital	10
East Cleveland Hospital	31
East Fifty-fifth Street Hospital	60
East Seventy-ninth Street Hospital	22
Florence Crittenden Home	12
Joanna Private Hospital	9
Mrs. Hitchcock's Private Hospital	15
St. Mark's Hospital	45
Salvation Army Rescue Home	54
Wright's Hospital	10
Total	290

In this classification it is to be noted that in conformity with the usual practice, beds (1) for the insane and feeble-minded, (2) for the infirm and aged, (3) in orphanages, and (4) under the control of the United States Government, have not been included. The list includes hospitals for general and special cases of an acute or chronic nature, and convalescents, but not the four classes mentioned above. This point is important in making comparisons with other communities.

If these beds are compared with the population of the cities of Cleveland and Lakewood, taken together, we should find that there are 3,378 beds to a population of approximately 840,000 in these two cities. However, these beds are serving more than the population of Cleveland and Lakewood. They are used by what may be called the metropolitan district, and even more distant areas depend upon them. We may form a definite estimate from data collected by the Survey on the two days, December 3, 1919, and January 15, 1920, on each of which was taken a census of the patients in the Council hospitals and in three others. A tabulation of the patients in these hospitals on these two days by location of residence (the average of the two days) showed that of the 2,651 patients 14.7 per cent., or practically one-seventh, came from outside the city of Cleveland. This number includes of course those coming from Lakewood, but it is certain that at least one-eighth of the patients who were in the hospitals on these two days came from outside Cleveland or Lakewood. At least one-eighth therefore should be added to the population served by the hospitals on our list, which would make a total of about 945,000. Dividing this by the number of beds, 3,378, we find that there is provision to the extent of about 2.8 beds to one thousand of population. This is a fundamental figure, because it is an index of the degree of provision of hospital service for community needs. Its significance will require elucidation.

Comparisons must needs be made with other communities. In the 1919 report of the United Hospital Fund of New York City, a classified list is given of the hospitals in that metropolis. There is shown a total of 28,208 beds,. which does not include the four classes of institutions mentioned above, or many small private institutions such as appear in the Cleveland list among the non-council hospitals. The proportion of patients coming from outside the limits of Greater New York is not known, but most of the suburbs of New York are better provided with hospitals than the outlying districts of Cleveland. It is assumed that the omissions from the list of hospitals in New York given by the United Hospital Fund would probably balance in number the beds required to serve non-residents. On this basis, provision of hospital beds in the metropolis in proportion to population is five per thousand.

Boston provides another basis of comparison. The legal city of Boston is a little smaller than Cleveland, according to the 1920 census, 727,000 against 796,836, but Boston is one of some 38 towns and cities within the metropolitan district, with a total population of approximately 1,500,000. A list of hospitals in this "Greater Boston" showed, from figures in the Medical Directory of 1918, 140 hospitals, general and special (excluding those types above named) with a total of 7,247 beds. This is 4.83 beds to 1,000 of population.

Taking the city of Boston alone, with a census population in 1920 of 727,000, it was found that there were 108 hospitals, with 6,062 beds. This is an average of 8.3 beds to 1,000 population, but this figure should not be used for comparative purposes, since so large a proportion of the Boston beds are used by the metropolitan district, with double the population of Boston proper. For purposes of comparison with Cleveland, the figure for the metropolitan area should be taken. It will be observed that the figures for New York and for "Greater Boston" are almost exactly the same.

It is apparent that Cleveland falls far below either Boston or New York in providing hospital service in proportion to its population. On the basis of five beds per thousand Greater Cleveland needs fully 4,725 beds, or at least 1,350 more than now exist. In view of the fact that even when new beds are planned for, time is required to build and equip the hospitals to contain them and that population needs continue to grow, it may be conservatively estimated that Cleveland needs to add 1,500 beds to its hospital capacity as quickly as possible. Even at the present moment (June, 1920) it must be recalled that while the 1920 census showed a smaller population for Cleveland than had been anticipated, yet the growth of the suburbs, which must depend largely upon the main city for their hospital service, has been proceeding at such a rapid rate that it is fair to estimate that not less than 1,500 rather than 1,300 beds should be stated as the shortage in the year 1920.

Were this merely a conclusion derived from statistics, it would be indeed questionable. The statistics, however, are worked out merely to give an index to well-established facts showing the shortage of hospital beds in Cleveland and the unfortunate results of this shortage. To depict these

will require a closer analysis of the service offered by the hospitals of the city.

The hospitals of Cleveland are predominantly devoted to surgery. On the two Survey census days, if the hospitals of the city were taken together (omitting City Hospital, Warrensville Tuberculosis Sanatorium, and Rainbow Hospital), it was found that 48 per cent. of the patients were surgical, and that in the majority of the hospitals the ratio was much higher. The reason that City Hospital is excluded is because in its 785 beds are included large groups of cases such as tuberculous, alcoholic, venereal disease and contagious disease patients, which do not appear in any other hospital. On the census days, only 21.5 per cent. of the patients represented general medicine, and only 9.4 per cent. special services. 18.7 per cent. were obstetrical, and 2.4 per cent. not stated. The figures themselves are given in a footnote.*

Cleveland is seriously deficient in provision for special classes of cases.† Obstetrical cases are found in the majority of the hospitals. The average for the two census days was 313, or about one patient in ten, 9.3 per cent. of the total patients in the Cleveland hospitals on those days. Provision for obstetrical cases in special hospitals is made only at Cleveland Maternity Hospital and at St. Ann's Maternity Hospital, a total of 115 beds. Recent years have seen a great increase in the demand for care in hospitals at the time of confinement, particularly by middle-class families, but these cases have had in the main to be provided for in the general hospitals, without the development of special hospitals, special services, or special wards to meet the particular need.

Regarding cases of eye disease, it was found that only one hospital, Lakeside, makes any special reservation of beds, four beds being held in the male surgical ward of Lakeside for this service. There is no special ward in the city for ear, nose and throat cases. In New York 608 beds are provided in special institutions for eye, ear, nose, and throat cases, aside from such provision as is made in the general hospitals. In Boston, 219 beds are provided; in Baltimore, 153; in Philadelphia, 58; in Chicago, 32.

In special provision for children, Cleveland is similarly lacking.

Pediatric services exist at Lakeside, City and Mount Sinai, and beds are set aside for children in the following additional hospitals: Children's Fresh Air Camp, Fairview Park Hospital, Huron Road Hospital, Lakewood Hospital, Rainbow Hospital, St. Alexis Hospital, St. Ann's Hospital, St. John's Hospital, and St. Luke's Hospital, making a total of 302 beds designated as children's beds, for other than contagious or convalescent cases.

*Classification of Patients, Census Days (averaged)

Type of Service	Number	Percentage
Medical	361.0	21.5
Surgical	805.5	48.0
Obstetrical	312.5	18.7
Special	157.5	9.4
Not stated	40.0	2.4

†In 1918 Boston had beds in special institutions to the number of 2698, as follows:

Tuberculosis	792	Children	240
Eye and ear	225	Women (maternity)	436
Contagious	340	Women and children together	542
Cancer	25	Convalescent	98

It will be observed that these are all parts of general hospitals. As compared with this, New York has 1,298 beds for children in special hospitals, and in addition, at least as many more beds specially set aside for children in a number of general hospitals; Boston has about 240 beds for children in special hospitals and more than that in pediatric divisions of a number of general hospitals.

On the two census days, there were 496 children found in the Cleveland hospitals, of whom 57 were in the contagious disease service of City Hospital. The vast majority of the remaining 439 were scattered through the wards and rooms of general hospitals, the greater number being surgical cases.

In the matter of provision for contagious cases, Cleveland has 100 beds at City Hospital. Boston has 340 beds in its City Hospital. In connection with contagious diseases, these figures are comparable, since both institutions rarely take cases except from within the limits of the legal city. It is stated by such a national authority as Dr. Charles V. Chapin that for the common contagious diseases (excluding tuberculosis, venereal diseases, etc.), a community should provide at least one bed for every 2,000 of population. This in Cleveland would mean almost 400 beds. Boston it will be observed has measured up to Doctor Chapin's estimate; New York, with 2,100 beds for contagious cases, almost meets it.

A special report of the Survey dealing with tuberculosis (Part IV.) has shown that Cleveland has not enough beds for this disease.

The estimates of the specialists in venereal disease are to the effect that at least 200 beds should be provided in the City Hospital, and that a certain amount of provision should be made in general hospitals. (See Part V.)

In the orthopedic service, a branch of medicine of rapidly increasing importance, Cleveland has an insignificant provision. The number of reported orthopedic cases in hospital beds, at the time of the Survey, was not known, except at Rainbow Hospital, which is chiefly designed for convalescent orthopedic cases of children. Boston has about three times the provision for orthopedic cases as has Cleveland, and New York has over 360 beds in special hospitals alone for acute cases of this type.

These facts go to show where the deficiencies in provision of hospital beds in Cleveland lie. The reason for the shortage of beds is obviously that the population has grown more rapidly than has recognition of needs for more hospital service. We find in the Cleveland hospitals the more urgent surgical and some medical cases being treated, but very little development of services for special cases. In general it may be said that the urgent diseases or emergent cases, particularly surgical, which force themselves on the community's attention and upon the attention of the individual hospitals, and which cannot be denied admission, have left little room for other types of work.

The effect of this shortage of 1,500 beds cannot be measured. We can only estimate the number of sick persons who have had to be cared for in their homes with inadequate facilities for diagnosis, for nursing, for diet, and for

care of all kinds. The number of cases of disease needing the services of a specialist, the complete and thorough observation necessary to make a diagnosis, such as is only possible under hospital conditions, we can only infer. We can only in imagination picture the suffering that has resulted, the development of slight illness into serious, the diminution of productive power, the loss of opportunity to prevent as well as to cure disease. Such shortage of hospital beds can only mean a waste of the vital resources of the population.

Against these figures ought to be set others which suggest an almost contradictory picture. If there were a shortage of beds, it might seem at first sight that the 3,400 beds now available should be constantly filled to their capacity. Such, however, is not the case. On the first census day, December 3, 1919, 2,581 hospital patients were reported as in hospitals with a theoretical capacity at the time of 2,831 beds. On the second census day, January 15, 1920, 2,663 patients were reported in hospitals having 3,001 beds. The percentage of beds filled on the census days for this group of hospitals, was 95.7 and 88.7, respectively.

A similar comparison can be made on the basis of an entire year, by taking the number of beds in the hospital and multiplying this number by 365, thus securing the maximum days of care that might be given during the year, Comparison of the actual number of days' care, as reported, with this figure gives the proportion of utilization of hospital facilities for the year. For the group of seventeen hospitals for which figures were obtained for the year 1918, a total of 929,825 days of care was possible but only 686,967 days of care were given, or 73.9 per cent. During the year 1919, for a group of sixteen hospitals, a total of 930,465 days of care was possible, but only 645,280 days of care were given or 69.3 per cent.

It should be stated at once that we cannot expect a hospital or group of hospitals to have all beds filled all the time. There are periods of epidemics, and in normal times there are occasional days when a hospital may have every bed taken, but such conditions are exceptional. A hospital may refuse cases when it has vacant beds, because there must be classification of patients to a greater or less degree, and the ward for which the patient is suited on account of his sex or disease may be full, while there may be vacancies elsewhere. Inability to receive a given patient is thus compatible with some vacancies in the same hospital. Over any considerable period of time during the year, there are many reasons why a certain number of beds cannot be completely utilized. Rooms and wards must be renovated and occasionally repairs are necessary. In many hospitals a certain number of beds are set aside for the temporary detention of patients, particularly children, during a period of observation so as to eliminate risk of contagious disease.

Such are some of the reasons why hospitals never show the use of their beds during the year up to anything like 100 per cent. of capacity. An annual average of 75 per cent. is a very fair showing. During the winter and spring months there is generally greater demand for hospital service

than during the summer and the autumn, and consequently a higher ratio of use of beds is usually found for the six months beginning with January, if compared with the other six months of the year. Hospital administrators may take advantage of this condition by doing repairs and renovations, so far as possible, during the less active months.

A tabulation of individual hospitals presents some interesting points, as shown by Table II in the Appendix.

It should of course be one of the prime aims of hospital administration to utilize the facilities of the plant to their fullest capacity. Good hospital administration should show a higher average use of beds than 70 per cent. for a year. Conditions will vary among general hospitals. Conditions in special institutions, such as hospitals for maternity cases, children, chronic cases, etc., must be considered on their own merits. Thus, in the Cleveland City Hospital, certain large units are set aside for tuberculosis, neurology (including many alcoholic cases), venereal diseases and contagious cases, and the demand for these beds is affected by many conditions different from those which affect the general medical and surgical services. It should, however, be the aim of hospital administration to make its internal arrangements as flexible as possible.* While contagious and acute surgical cases are not safely to be mixed in the same wards, there should be a constant effort toward the utmost flexibility of classification so that pressure on one division of the service can be relieved by rearrangements which utilize beds vacant in other divisions.

A comparison of Cleveland figures with those of a number of leading New York hospitals shows the majority of Cleveland institutions in a somewhat unfavorable light. Nineteen hospitals in the United Hospital Fund of New York showed in 1919 an average of 79 per cent. of their bed capacity filled. The lowest hospital showed 63 per cent. and four showed 90 per cent. or over.

On the whole it may be said that a general hospital should be so administered as to run to an average of at least 75 per cent. of its capacity during

*Figures provided by the City Hospital just before this report goes to press show, for the year 1919 and the first nine months of 1920, the details of the use of the different divisions of the hospital. These are as follows: (The figures in the parentheses are for the first nine months of 1920, and the others for the year 1919.)

Department	Beds	Total Days Treatment Possible	Total Days Treatment Given	Percentage Occupied
Tuberculosis	100	36,500	27,447	75.7
	(100)	(27,400)	(16,430)	(59.9)
Contagious	100	36,500	14,806	40.5
	(100)	(27,400)	(13,859)	(50.5)
Specific	75	22,500	13,575	60.3
	(125)	(35,250	(13,264)	(38.7)
Observation	50	18,250	12,077	66.2
	(50)	(13,700)	(8,938)	(65.0)
Main and Convalescent	400	146,000	105,001	72.0
	(380)	(104,120)	(74.614)	(71.7)

The very wide variations between the degree of use of the different services of the hospital are apparent. It will be noted that the small percentage of use, particularly of certain divisions, has continued throughout a long period of time.

the year as a whole, and that an average of over 80 per cent. should be expected during the busier portion of the year. A figure as high as 90 per cent. ought to be the goal.

In estimating the hospital needs of a large community, however, it would not be safe to expect a percentage of utilization of hospital beds as a whole throughout the year to be more than 75 per cent. at the present time, even in the face of a general shortage of beds with consequent increase of pressure. The Survey has sought to point out the necessary inflexibilities of hospital arrangements and the irregularity of demand throughout the year to account for this seeming inconsistency.

On the map on page 823 are shown the eight "Health Districts" used by the Cleveland Division of Health for administration purposes. The hospital population of the city on the two census days was tabulated with reference to location of residence of the patients according to these health districts. Comparison with the map will assist in interpreting Table III in the Appendix which gives this tabulation.

A glance at this table and at the map shows that the hospitals of the city have not been located according to any general plan, nor to any great extent with reference to the needs of any particular locality. Thus District II and District VIII show the largest proportion of cases in the hospitals, and this is what one might expect considering the congested residential character of District VIII, and also the enormous business and industrial population of District II, during the working hours. A large amount of need for hospital attention invariably arises under such conditions, yet the only hospital in District II is Huron Road, and the district has less than one-third the number of beds per thousand of population that are provided in Health District III, which, with three times the proportion of beds according to population, shows less than one-third the number of hospital cases per thousand. Comparison with District VII is also instructive.

A number of hospitals are found located near the boundaries of districts, and belong to the one as much as to the other, but the more fundamental fact is that the range of service of many hospitals has very little relation to the district in which it is located. Table IV in the Appendix shows the proportion of cases on the first census day registered in each hospital from its own health district.

Further study of the individual hospitals on the second census day and in some cases for other periods, showed quite clearly that hospitals can be divided into two groups, with respect to their range. One type, such as Huron Road, Lakeside, City, Mount Sinai, St. Luke's, and St. Vincent's, have what may be practically called a city-wide range. The proportion of cases drawn from their own vicinity is no larger, or is less than one would expect in proportion to distribution of population. In the other group are hospitals such as Fairview Park, St. John's, Glenville, Lutheran, Provident, Grace, St. Ann's, and St. Alexis, which show a large proportion of patients drawn from their own vicinity. The difference between the two classes is often more striking when the figures for the individual hospitals in the latter

class are examined in detail. In some instances from two-thirds to three-fourths of the patients are found to be drawn from the hospital's own district or a neighboring district, so that the great bulk of the hospital clientele is local. Generally speaking, the range of the larger hospitals is wider than the range of the smaller ones.

The facts shown in these tables are of importance in connection with the location of future hospital units, and will be referred to later in that connection in the section on Community Planning.

It is important that each board of trustees understand the range of its own hospital. Adaptation to the special needs of its clientele is a very different matter in a hospital which serves primarily its neighborhood from the case of one which draws from all over the city and from the environs.

The most important summary conclusion to which the data in this section lead is the shortage of 1,500 hospital beds in Cleveland in 1920. The work of the existing hospitals has been unduly limited, because of this shortage, to urgent surgical and to maternity cases. Medical and special work, particularly for children, has not been provided for in any adequate degree. Study of the Cleveland hospitals reveals these conditions quite clearly, and they are thrown into relief by comparisons made with New York and Boston. It is apparent that while the best administered hospitals of Cleveland have used their beds to as full capacity as the best institutions elsewhere with which comparisons have been made, the hospitals in Cleveland as a whole have fallen below a desirable percentage of utilization of their theoretical capacity, even in the face of the community's need for beds. Some of the reasons for this have been indicated, and the need for flexibility and efficient administration has been pointed out as a remedy.

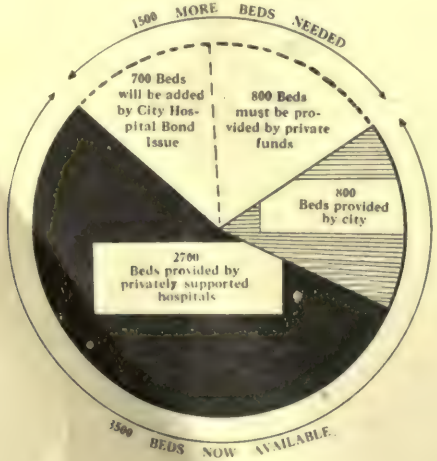

Fig. II.

Provision and Need for Hospita Bens

Distribution of hospitals according to sections of the city shows lack in the past of any general planning and the need for the formulation of principles by which the locations and functions of future hospitals can be determined. It is apparent that there is special need and large demand for hospital service coming from the central section of the city, and inasmuch as a considerable part of the need from this section is known to be of an urgent character, future plans for the location of hospitals must take into consideration local provision for this central section.

It has been sought in this section to point out not only general matters of interest to the city as a whole, but to indicate some of the kinds of facts which hospitals need to know about themselves; which the trustees and their representatives should have periodically reported to them. In how many hospitals do the monthly reports to the trustees show, for instance, the percentage of beds used in each of the main divisions of the hospital in proportion to the theoretical capacity of each division? Shrewd business men know just what facts to demand in regular reports from their own enterprises so that they shall be able to determine whether or not the business is well run. Trustees should be as discriminating in the selection of the facts which they ask to have set up as the guideposts for the business and policy of their hospitals.

ORGANIZATION FOR SERVICE

A hospital is much more complex than most business organizations of equivalent size. Its peculiarity is the inclusion of a number of different professions, each highly specialized, which must work together and which must be kept in effective working relations. The basis of a hospital is its medical staff, but in addition to this medical element, is the business administration, represented by the business men of the trustees, by the superintendent, and by his administrative assistants; the nurses, another highly specialized and well organized group; social service, representing still another and different type of work in the hospital; and finally, the housekeeping, mechanical, and clerical groups, who maintain the essential daily routine of the plant. It should be added that while the emphasis of the work of most superintendents is on the business side, the superintendent ought to interpret, develop and represent all phases of a hospital's activity.

Hospital personnel thus includes such widely varying elements and draws them into such intimate relationship that the successful organization and administration of a modern hospital is a difficult matter requiring special training and skill. There are stated at the end of this chapter a series of recommendations regarding hospital organization to which the discussion of this chapter aims to lead, and which it endeavors to interpret.

The basis of hospital organization may be one of three types. The first, which is found only in the proprietary hospital, is a group of stockholders or owners of the hospital corporation, who may or may not have an interest in the professional and welfare activities of the institution. The second type, as represented by City Hospital, is under the direction of a single man, the Director of Public Welfare, who appoints the executive officer and staff of the hospital. The third type, the usual form of organization of privately supported hospitals, is that of a board of trustees. Certain hospitals which are under the control of religious organizations fall somewhere midway between types two and three.

It is proper enough that there exist proprietary hospitals as a form of business enterprise meeting an apparent public demand, but no hospital which aims to be in the public service class can expect to receive public confidence and support unless it has as its governing authority an individual or group possessing the point of view of public service, without financial interest in the operations of the institution.

The conditions found in the City Hospital of Cleveland indicate very clearly the need for more general public interest in an institution of major importance, such as this. The most serious administrative deficiency found at the City Hospital by the Survey was in the nursing service. So great a shortage of nursing service was found that the conditions amount to a serious neglect by the city of its solemn responsibility for the humane care of sick and helpless citizens. It is recognized that the ultimate responsibility rests with the citizens of Cleveland, who should have appropriated more money for the maintenance of City Hospital. More immediately, the responsibility rests

with the appropriating authorities of the Cleveland municipal administration.* The executive officers of the Department of Public Welfare and the City Hospital should be held responsible for voicing the need in a clear, effective, and persistent way, both to the appropriating authorities and to the public. There is not evidence that sufficient attention has been called to the conditions by the administrative officials who have been aware of them.

In the nursing service of City Hospital a decided shortage of students exists, and in some instances, of the supervising staff also. It is a conservative estimate that there are only about one-third as many students as are needed for the number of patients, as 63 students are assigned the 481 beds used for training—a ratio of one student to 7 or 8 beds. The ratio of students to beds was in actual practice lower than this—one student to 10 beds in the general services during the day, and one student to 40 beds at night. Due to the shortage of student nurses, ward attendants have had nursing duties assigned to them for which they were entirely unqualified.

The presence of a board of trustees or of a visiting committee who were actively interested in the hospital might probably have been of great service to the administrative officers of the hospital and to the Director of Public Welfare in making apparent to the municipal administration and to the general public the needs of the City Hospital and the gravity of the present deficiency. As the Survey has recommended, an appropriation of $150,000 a year for nursing service is necessary for at least the next year or two in order to secure a sufficient number of graduate nurses to provide a minimum of satisfactory care for the patients. If, as the Survey has also recommended, a sufficiently capable head of the training school can be secured with an adequate corps of trained assistants, it is probable that the training school can be so built up that the amount just mentioned can be diminished in future years, as an increased number of student nurses is received, up to the maximum for which the hospital can provide suitable training.

At Warrensville Infirmary the lack of medical and attendant service is also grave, and here again the institution has been lost sight of, even by sections of the public which, if they knew the facts, would be interested to arouse public opinion to better conditions. The need is not only for more medical staff and attendants at Warrensville, but also for recreational facilities for old people and others who are patients and who need some element in their lives beyond the barest minimum of physical care; also for the employed help of the institution, who, particularly under present economic conditions, are obtained with difficulty in a place which is relatively isolated in comparison with other places in which as good, if not better, wages, can be secured. Much in this direction would gladly be done by volunteer assistance if the right people knew the facts and were interested to be active in the matter.

It has been recommended by the Survey that the Cleveland City Hospital be governed by a board of trustees, which would require a change in the

*It is recognized that legal restrictions upon municipal taxing power have placed considerable limitations upon Cleveland's expenditures for public services, as in many other cities.

city charter. It may be pointed out that from the standpoint of efficiency, government by a director need in no way suffer in comparison with government by a board of trustees. The effectiveness of either form of government depends upon personnel, the recommendation in favor of a board of trustees being chiefly that of greater stability through changing municipal administrations. This again may work for good or ill, depending upon personnel. At some periods it would serve to retard progress, and in others to prevent disruption following a political overturn. On the whole, however, a board of trustees is desirable.

Even under the most ideal conditions of municipal administration, a city hospital needs to be brought in contact with its community, and this can best be secured by attaching to the institution in some way a group of disinterested citizens, men and women, who will visit it, be in touch with its work, help its governing and executive officers by friendly advice, and above all else, interpret the institution, its work, and its needs to the financial appropriating authorities and to the public as a whole. The formation of a strong board of trustees best accomplishes these purposes, but if this proposal proves unacceptable, some progress toward the same result may be accomplished by a properly selected visiting or auxiliary committee, appointed by the Director of Public Welfare; such a committee of course having only advisory powers. The degree to which such a board will be of practical service will depend almost entirely upon the Director. He has it in his power to stimulate the board to activities which will not interfere with the hospital's activities but be of benefit, or, on the other hand, he may reduce the group to one on which few capable individuals will find interest in serving. In the absence of a board of trustees, however, the presence of some such advisory body is highly advisable.

A hospital which is managed by a religious sisterhood will do well, as four such hospitals in Cleveland have recently done, to appoint a lay advisory committee which will exercise much the same functions as a board of trustees though without the legal authority usually vested in them in other hospitals.

For the typical hospital, privately incorporated, there should unquestionably be a board of trustees. Such bodies are usually either self-perpetuating or elected by a hospital membership or by church or other organizations which constitute the hospital corporation. Members of boards should have definite terms, and the personnel should change slowly, a few terms expiring each year. Many of the chief deficiencies in hospital administration in Cleveland and elsewhere have arisen because of defects in the make-up of the board of trustees or in its relationship to other groups in the hospital organization. The composition of boards of trustees has too frequently been determined by an historical accident which threw together a group of doctors and lay business men who together made up the original body, or on the other hand the board is composed entirely of business men, who are usually immersed in affairs, and leave to the medical staff or to one or two of their own number, practically the whole responsibility for administration of the institution.

Perhaps the most frequent cause of difficulty in Cleveland has been the existence of a number of different boards or groups within the same hospital, without clear definition of their respective powers and duties. Thus there may be found a board of trustees, a board of managers, and an auxiliary board in the same institution. The personnel of one of these groups may be entirely women; of another, entirely men; the third may be also of women, or of both men and women. The original reason for the formation of these different bodies was obviously the desire to interest as many persons as possible in the hospital for the sake of moral and financial support. Principles of organization applicable to hospitals as well as to business establishments require that there shall be one governing authority. The existence of other boards or committees is not inconsistent with this principle, but the provisions of the by-laws and the actual practice of the hospital should make it quite clear that a single body which should be known in general as the "Board of Trustees" has complete authority*, and that all other committees or groups have advisory powers or delegated powers only; nor should powers be delegated by the board save to committees which include some of its own membership. Delegation of power to other committees almost invariably leads to division of authority and confusion in administration.

In a few hospitals where numbers of different boards and committees exist, a simple remedy is practical—consolidation. There are usually found a certain number of active members within each committee, just about enough altogether to make a single effective governing body.

A board of trustees of a hospital ought to include within itself all the chief elements with which the hospital is concerned. Boards frequently suffer from being composed entirely of business men. Boards of trustees should include other elements which enter deeply into the work of a hospital. Education is one of a hospital's interests, in relation to nurses, to medical study, and to the community in general along health lines. Every hospital, particularly those connected with medical schools or maintaining training schools for nurses, should include in their boards one or more persons interested in or connected with educational activities. Men and women concerned in the philanthropic and social service relations of a hospital likewise represent an element which ought to be on every hospital board. Selection of personnel from the business, educational, philanthropic, and other elements which ought together to make up the circle of interests of a hospital is no easy task, for the group as a whole must not be too large, it must be harmonious, and must be capable of prompt and effective action. Such mingling of interests in the personnel of a board is a goal to be sought for. Men experienced in the management of business affairs constitute a necessary and valuable element, but men and women interested and concerned with other activities need to be sought for and included.

It is perhaps not quite clear to the average person why the physicians who do the medical work of a hospital should not be members of its board of trustees. The accumulated experience of hospitals throughout the country

* It is well to restrict the use of the word "Board" to this one body, and to use the term "committee" for all other groups, medical and lay.

is against such membership. The physician who is on a hospital staff or who is in active practice will have, if a member of the board of trustees, a double position and a double interest. The word double is not to be interpreted as meaning selfish. As a member of the board, the physician is in a position of authority over the hospital policies. As a member of the staff, he is connected with the conduct of a definite piece of work—carrying out these policies within the hospital. So long as hospital staffs are made up of practising physicians, each of whom gives a portion of his time to the hospital service, the selection of a few of these men for membership on the board of trustees is certain to create difficulties. The medical knowledge and interest of the physician is the professional guide to which the board of trustees must give attention, but this guidance from the medical staff can best be furnished through the medical staff's own organization, acting as a professional body and related to the board through a suitable committee and through the superintendent.

The nursing work of a hospital is another element of great importance in the daily administration of the hospital, and one which at the present time presents especial difficulties. A special section of the report of the Cleveland Hospital and Health Survey is devoted entirely to nursing (Part IX.) Here it may be mentioned merely that the relation between the nurse and the hospital administration in the past has been largely through the nurses' training school. As the nursing report shows, hospitals have been too ready to utilize their training school for nurses as a means of securing cheap labor. Part of the young woman's payment for receiving education in nursing has been rendered by giving manual service. Nurses are too much in demand to permit these conditions to continue. While part of the education of a nurse lies necessarily in the hospital and dispensary, where practical experience must be gained, the education of the future nurse and the daily conduct of the hospital routine cannot be identified so closely in the future as they have been in the past. The education of nurses must stand in a greater measure on its own feet, as an educational enterprise, affiliated with the hospital more along the lines of the affiliation between medical school and hospital. The routine work in caring for patients must be conducted in a larger measure by women who have already had their educational training for the work, and who do not receive an educational course as part of their compensation. The varied activities which have been carried out in the past by the graduate nurse and the pupil nurse must in the future be conducted by an apportionment of tasks among graduate nurses, attendants, maids, and orderlies.

In its relation to hospital organization, this may mean physical separation between the training school and hospital in many instances, as outlined in the nursing report. The conduct of training schools by hospitals as part of their own organization requires special knowledge and usually a special committee, in order that educational policies may be developed, and educational standards maintained. For these reasons, the special training school committee recommended in the plan of organization is deemed desirable. The relationship proposed between the trustees, the training school committee, the superintendent of the hospital, and the head of the nursing service, should be considered carefully.

The social service department represents the newest element to enter the hospital, and its position as yet has not received universal recognition. In a number of the best institutions, however, in Cleveland and elsewhere, the social service department is developed and its place is fairly well defined. Few boards of trustees and few superintendents have at the present time sufficient knowledge concerning the policies and the methods that should prevail in a social service department to be able to guide it properly. A special social service committee is therefore thought desirable, to serve with advisory powers only, and to help in developing the social service of the hospital so as to be of the maximum assistance to its medical work.

A failure on the part of the board of trustees to give sufficient authority to their executive officer, the superintendent, is another source of weakness in not a few hospitals in Cleveland as elsewhere. More than one executive head in an organization is an obvious weakness and danger. To manage a modern hospital with all of its varied interests and all the widely differing groups within its personnel, requires a man or woman of unusual ability and tact, and with special training. Everywhere in the country the number of such qualified persons is at present far below the demand. The board and its advisory committees need to supplement the superintendent in advisory as well as in directing ways. It will be observed that according to the plan for hospital organization outlined in the following, the superintendent stands in a central position, meeting with the board on the side of hospital administration, and with the medical executive committee on the side of the hospital's professional activities.

A third aspect, which is not mentioned in the plan of organization, but which may be taken for granted, is the superintendent's relation to his administrative departments; the steward, the dietitian, the engineer, as well as the head of the nursing and of the social service departments. Periodical conferences between the superintendent and the administrative group are desirable. Medical, nursing, social, and administrative interests within the hospital render it desirable that from time to time representatives of all the different groups be brought together for their better mutual understanding. Recommendation number 6 points in this direction. It is particularly important that members of the board of trustees shall understand personally the hospital inter-relationships and the different parts of its work, and that they shall come into contact at first-hand with sources of information. Through such conferences held from time to time for the discussion of selected problems, this can be achieved. There is no stimulus to members of a managing board like direct contact with facts and with the people who are doing the work over which they have authority.

"What is the whole duty of a Trustee?" is perhaps the fundamental question concerning hospital organization. How is a man or woman living in a great city and with business or other definite vocation, to give sufficient time to a hospital really to understand its work and to be able to meet to the full the responsibilities of trusteeship? The question cannot be answered in general terms, for the activities of a modern hospital are so varied and so technical that few members can come into sufficient touch with all of them to have sound judgment upon all questions that may arise regarding any

one of them. Yet, by division of labor among the members of a board, and above all, by a really active sense of responsibility made effective through the leadership of the president or other officers, a reasonable degree of knowledge of the work of the hospital can be gathered by each member, and the sum total, when the board gathers together, will be sufficient to render the trustees a truly responsible governing body.

It is of particular importance that the trustees understand what facts they should know of periodically, so that these may be presented in the monthly and annual reports of the superintendent. The percentage of beds used in each division of the hospital has already been mentioned as one of these important facts. The length of stay of cases in the different divisions of the hospital is another. At the time of the Survey census, it was found that taking the general hospitals of Cleveland as a whole, 44.6 per cent. of the patients had at that time been in the hospital from three to fourteen days, 13.2 per cent. had been in the hospital less than three days, 19.2 per cent. between fourteen and thirty days, 9.2 per cent. between one month and two months, and 12.9 per cent. more than two months (9% not stated). The proportion of cases staying for these longer periods is higher than it should be in hospitals designed primarily for acute stages of disease. The reason lies largely in the lack of dispensaries and of facilities for convalescent and chronic patients in Cleveland, to which attention will be devoted later in this report. A study of individual hospitals showed wide variations in this figure, ranging from no patients staying over sixty days to as high as 29.9 per cent. A report showing the length of time that patients have been in the hospital, and the number in the various divisions of the hospital who had been there more than a normal period, should be of distinct value to the trustees as well as to the medical staff and the superintendent.

Statistical record of patients who have been refused admission is another item of significance. Monthly reports should show the number of refused cases, classified by the main type of case, i. e., medical, surgical, children's, etc., and classified also according to whether the applicant was for a pay, part-pay, or free bed, and with classification according to reasons for rejection. Not a few hospitals fail to keep any memorandum of cases refused admission because of lack of room or other reasons. Data as to whether or not a waiting list is maintained, or whether refused cases are placed on the waiting list, are also of value, although the maintenance of a waiting list is not always practicable.

Statistics regarding the results of care have been developed somewhat through the American College of Surgeons, but their further development and the regular reporting of the condition of patients at discharge and at specified periods thereafter should be part of the regular reports of hospitals in the future. Similarly in dispensaries, the trustees should know what proportion of patients pay one visit and never come back to continue needed treatment.

Those items are mentioned here merely as illustrations and of course are in addition to the ordinary statistics of the number of patients admitted, the number of units of work done in each of the chief divisions, and the financial

figures showing income and expenditures for the various departments of the institution. In the section on individual hospital planning we shall return to this subject and summarize the more essential facts which a hospital or dispensary should gather and present regularly for the information of its governing body, its supporters and the public. To substitute guidance by facts for guidance by impressions and by hearsay is the goal of the best administration.

SUMMARY OF PRINCIPLES OF HOSPITAL ORGANIZATION*

1. The final governing authority of the hospital should be a Board of Trustees. No member of the Board should be a member of the active or consultant medical staff of the hospital. Hospitals which are under a religious or public city or federal organization and which therefore cannot have Trustees, should appoint an Advisory Committee similarly constituted. In addition to the men members of the Board of Trustees who represent chiefly financial, administrative and broad public interests and experience it is of much importance that there be included on the Board of Trustees a representative of some institution of higher education, viz: University, Normal College and women members whose experience and interest can be relied upon to contribute constructive ideas and opinions.

2. The appointment of the medical staff should be vested in the Board of Trustees. All members of the staff, chiefs of services, or assistants should be appointed by the Board for terms of one year renewable by the Board. The nomination should be made on the initiative of the Board of Trustees or of the Medical Staff or of an executive committee of the medical staff. The Board of Trustees should consult with the Superintendent, or Chief Executive Officer, before confirming the nomination of a Medical Staff, or of individual members thereof.

3. The Superintendent of the hospital should be appointed by the Board He should have entire administrative authority over all departments of the hospital. Under the rules and regulations adopted by the Board of Trustees, the Superintendent of the hospital should have authority to nominate or appoint all heads of departments and employes. This implies the authority for discharge or dismissal of any employe for cause. The superintendent should be the representative of the trustees in relation to the staff or outside interests.

4. The medical staff should be definitely organized for the promotion of team work, common policies and satisfactory relations with the administration of the hospital. Regular meetings of the medical staff or sections thereof should take place for the discussion of professional work. For guidance in organizing such professional conferences the recommendations of the American College of Surgeons are called to the attention of the medical staffs of hospitals. The staff should be organized into divisions or services, medical, surgical, etc. It is desirable that there be a recognized chief for each division.

* Prepared in collaboration with Haven Emerson, M. D., Director of the Survey, and W. L. Babcock, M. D., consultant on Hospital Administration.

(a) Provision should be made in the By-laws of the Hospital for the recognition of physicians, not members of the staff, whose practice in the hospital complies with definite hospital standards. It is recommended that these physicians organize into an auxiliary staff, without service or voting power, and that a delegate or delegates from this staff be recognized by the Trustees and Attending Staff as their representative.

5. There should be a Medical Executive Committee composed of members of the medical staff, selected by the medical staff or by the Board of Trustees on the nomination of the medical staff. The Superintendent of the Hospital should be a member of this Committee. The total membership of the Committee should not be so large as to be unwieldy. Seven members is generally the maximum desirable.

6. It is recommended that the Board of Trustees of hospitals arrange for periodical conferences of designated members of the trustees, of the medical executive committee, the superintendent and administrative officers such as the heads of the training school or nurses' service, and of the social service department. This joint group should meet periodically for the discussion of hospital policies or administrative matters.

7. The staff of the dispensary or out-patient department should be appointed according to the principles above laid down and the physicians serving in the dispensary should receive definite recognition as members of the hospital organization and staff. For each department of the dispensary there should be designated a chief of clinic who should be under the general authority of the chief of the corresponding department of the hospital, but who should be directly consulted by the superintendent or the assistant superintendent who is in charge of the dispensary on all matters affecting the dispensary. The chiefs of the dispensary service should constitute a Dispensary Medical Committee which with the superintendent, the assistant executive in charge and such others as may be designated should meet from time to time on dispensary matters. It is suggested that a representative of the dispensary staff be a member of the Medical Executive Committee.

8. The medical staff of the hospital acting thru the Medical Executive Committee and the Superintendent should formulate a definite set of standards, subject to ratification by the Trustees, for all professional work of physicians in the hospital touching such matters as attendance, the making and supervision of records, diagnosis, use of laboratories, X-Ray and other diagnostic aids, the duties of residents and internes, the inter-relation of staff physicians and outside physicians, the matter of fee-splitting, etc.

9. Physicians not members of the hospital staff should be entitled to send to the hospital and to treat therein private cases in rooms or wards, subject, however, to such limitation as to number of beds to be allotted to outside physicians as may be formally made by the Trustees, and provided that the physicians treating such cases conform to all standards made by the Medical Staff.

10. No physician should receive a fee from patients other than such fees as may be permitted to staff physicians nor should any physician receive a fee from a patient unless the charges for the hospital care have been met according to the rate established for various rooms or wards for members of the staff and outside physicians alike.

11. In such hospitals as may still continue to keep a training school as part of the hospital organization there should be appointed by the Board of Trustees a training school committee composed of both men and women, to direct educational policies. This committee should include representatives of the Board of Trustees, with other persons known to have had experience in education, and also members of the alumnae of the nurses' training school. The superintendent of the hospital and the director of the training school in the hospital and representatives of the medical staff selected by the medical executive committee, though not members of the training school committee should sit with the committee.

Among the Catholic hospitals or in hospitals administered under a religious organization which have no boards of trustees and are subject to the direction of the Bishop of the diocese, a committee on the training school, advisory to the Bishop, might with advantage be established at once to direct the educational policies of the training school.

The relationship between schools of nursing and hospitals should be essentially the same as that created between medical schools and hospitals. The School of Nursing, like the medical school, should exist primarily to give technical education to students who are to obtain part of their training in the hospitals.

An ideal organization for a school of nursing which should be realized in Cleveland as soon as circumstances permit is clearly the University organization in which ward training would be given in such hospitals as come up to the conditions required by the University for educational purposes for its students.

12. The superintendent of nurses in the hospital should be appointed by the Board of Trustees of the hospital, on nomination of the superintendent of the hospital with the concurrence of the training school committee. She should have administrative authority, subject to the superintendent of the hospital, over the entire nursing service and she should be responsible for the educational standards and policies as laid down by the training school committee. It is considered desirable that the superintendent of the hospital should delegate to the superintendent of the training school the appointment and dismissal of nursing personnel.

The offices of principal of the training school and superintendent of nurses, are educational and administrative offices, respectively, and may or may not be combined in the same individual. When they are combined the head of the training school should be designated "Superintendent of Nurses and Principal of the Training School."

13. The Social Service department of the hospital should be under the direction of a head worker who should be responsible to the superintendent. It is recommended that there be a Social Service Committee, which among other members, should include one or more of the trustees, of the medical staff and the superintendent of the hospital.

THE HUMAN PROBLEM OF THE HOSPITAL PATIENT

"Treat not only the disease, treat also the man." These words of Rudolph Virchow set the standard for the highest form of hospital service. The two or three thousand patients who are in the hospitals of Cleveland daily, present the hospitals not only with a variety of bodily ills, but with problems of personality and environment which are as varied as human nature, and which influence vitally the ultimate success of the hospital's mission to maintain as well as to restore health.

Virchow's words set not only a standard but express a warning, for the hospital's great danger is overspecialization—attending to pathology and overlooking personality. Successful work in the operating room may be independent of what the patient is or thinks or feels, but successful restoration of the patient to health and living efficiency depends not only on the surgery but on the patient's state of mind after he goes from the operating room to his bed in the hospital and from his bed in the hospital to his home.

In a survey it is necessary to consider persons as well as patients, in order that a true picture be given of the hospital's services, of their relationships to the community, and of their values and deficiencies, as judged by the final results in making people well and humanly efficient. The Survey has therefore endeavored to study the people and their reaction to the hospitals of Cleveland as well as the hospitals of Cleveland in their relations to the people. Several hundred interviews and conferences were held with physicians, including both members and non-members of hospital staffs; with nurses in hospitals and in public health fields; with social workers; with organizations of the foreign-born; with church workers; and with people met more or less at random in their homes or elsewhere.

Those who are accustomed to hospitals too often fail to recognize how new and strange an experience, to the average patient, is his first contact with a hospital. The admission procedure, the unfamiliar antiseptic odors, the sight of many sick people, the precise business-like efficiency of hurrying nurses and doctors, fill many a patient with vague and uncertain ideas of what may be going on behind the many closed doors, and what may soon be happening to himself. Courage is easily lost in the strange institutional atmosphere. The educated man who is familiar with hospitals, having previously been a patient or a visitor, and who is self-confident and at ease even during sickness, is in quite a different position from the uninformed immigrant who has never had contact with doctors or hospitals in his life, or the timid woman, or the sensitive child.

It is not that hospitals or their personnel lack kindness in the treatment of the patients. It is their business to be helpful, and hospitals and their doctors, nurses, and other personnel generally are, but it is rather that hospitals are helpful in a professional and technical way, while the patient is generally full of worrying questions he would like to have answered, of forebodings which it would be desirable to dispel, of states of mind which depress him, and which, if maintained, will hinder his recovery. These forebodings

and these states of mind require not merely a general attitude of kindness, but sympathetic insight, clear analysis, and definite action to dispel.

The human problem of the hospital patient can be perhaps best illustrated by the foreign-born. On the two Survey census days, 63.1 per cent. of the adult patients were American-born, and 36.9 per cent. were foreign-born. According to the estimates in 1917, of the Cleveland Americanization Committee, there were 744,728 total population in the city, of whom 231,939 were of foreign birth, 466,142 native born of native parents and 281,586 native born of foreign or mixed parentage. Those of the third group are largely children. Taking these figures, we find that the 231,939 foreign-born are 49.7 per cent. of the 466,142 native born of native parentage. This figure may be roughly compared with the percentage of foreign-born adults in the hospitals of Cleveland, which was just stated as 36.9 per cent. This illustrates an important point which studies in other communities have verified —that the foreign-born adult generally uses the hospitals less than the American-born adult. This is largely because of lack of familiarity with an institution with which many immigrants had little experience, previous to coming to this country. It must be remembered that a large number of recent immigrants have come from small towns and many of them think, "Hospitals are places where you go to die." A considerable proportion of the foreign-born patients, moreover, speak little or no English.

The attitude of the foreign-born toward the hospital reflects all the lights and shades of the hospital's own attitude toward its patients of foreign birth. Frequently the very human and impressionable surface which the foreign-born presents ready for the hospital's sign and seal, is masked behind an enforced silence because of unintelligible speech. Too often the phrase "those ignorant foreigners" shows merely lack of understanding by the American-born. A common language is the searchlight most useful in discovering physical, racial, or temperamental needs, and means of adjusting the hospital regime to treat these. When the hospital has given time and thought to its task, it has been able through sympathetic interpretation to convince the patient of its friendly interest, its ability in diagnosis, its skill in treatment, and when this conviction is made doubly sure by intelligent follow-up work in the home, there is every evidence that the hospital's work is worth while, that the patient is grateful and appreciative, and that the experience has been of permanent educational value to him in the matter of personal and public health and in the growth of a sense of social and civic participation.

The result is different when the hospital has had no specific machinery for getting at the back of the foreign patient's mind, and making the somewhat inflexible and mysterious hospital routine less a puzzle to him. The patient's mild skepticism as to whether American hospitals are good places for the foreign-born, increases to a large doubt. This is further enlarged by his friends, who have trouble in being understood at the inquiry desk; who may be unable to talk with the doctor or to get the diagnosis. If a medical case, the patient worries through a retarded convalescence and goes home glad to be free—and wondering. If a surgical case, often his climax of

protest against the vast unknown of hospital machinery is a refusal to permit operation. He leaves against advice, grateful for the somewhat peremptory discharge of the hospital, which in turn, feels inwardly affronted that its effort to help should be powerless before his unreasoning "stupidity."

In seven hospitals the proportion of foreign-born adult patients was over 30 per cent., the maximum being as high as 47 per cent. No hospital in Cleveland has made any definite provision for interpreters, either as a matter of promoting the ease and comfort of the patient, or of increasing hospital efficiency. As a rule the hospital is concerned with "making the patient understand"—"We manage to make them understand somehow." Some other patient of the same mother tongue who has learned English is pressed into service, or an employe or a visitor is called upon. The problem, however, is not merely "making the patient understand," but is to render the patient "understood."

The following table, based on the average of the two Survey census days, showed an interesting phase, the contrast between the proportion of pay, part-pay, and free patients among the adult foreign-born and the American-born patients in the hospitals of Cleveland.

HOSPITAL PATIENTS ON TWO SURVEY CENSUS DAYS, AVERAGED

	American-born		Foreign-born	
	Number	Percentage	Number	Percentage
Pay	989	39.2	351	23.8
Part-pay	735	29.1	444	30.1
Free	733	29.1	631	42.8
Information not furnished	66	2.6	48	3.3
Total	2,523		1,474	

The table indicates what one would expect, that the foreign-born show a much larger proportionate use of the free beds. The generally higher economic status of the American-born is doubtless sufficient explanation.

One important relation of the hospital to the community is the furnishing of information about the condition of patients. Patients themselves want to know how they are getting on, and their relatives and friends likewise wish this information. Hospital staffs and administrators must use their discretion in what they tell the patients or relatives, just as private physicians do, yet the hospitals often fail to give elementary and necessary information or to give it in a way which will be helpful or even useful.

Many inquiries come by the telephone. A story has been reported of an immigrant family, very anxious to secure information as to the condition of the father who had been taken to a hospital after an accident. Unable to

speak English, the mother and her children had recourse to the neighborhood druggist. He called up the hospital three times, and was unable to learn anything that would either satisfy himself or relieve the family's acute anxiety. The error was not inhumanity on the part of the hospital, for the information was later furnished readily, but was due to the fact that the telephone operator had not been taught to appreciate the importance of interpreting the hospital to the public. This incident would not be mentioned were it not an illustration of many.

The importance of this duty is often not sufficiently clear to the hospital administration to make them provide adequate instruction to the person or persons who are responsible for answering such inquiries, either in person or over the telephone, or to cause the selection of a sufficiently trained and tactful person to perform this function.

Sometimes a mother is eager to see her child frequently. There are often perfectly good reasons why she should not see the child at all or during certain periods, but not infrequently there is failure to explain to an anxious family why the privilege is denied.

Interpretation of the hospital's work, rules and results to the public is part of the hospital's job. The public includes its own patients, their relatives and friends, and also the broader circle of the hospital's supporters, and any one in the community, in fact, who has a reason to be interested in the hospital's activities. This interpretation of the hospital's work, rules and results, is made partly in the hospital's formal reports and partly through its daily relations with its patients and those interested in them. Too little attention has been given to such interpretation through the channels of the hospital's routine contacts.

The patient's lack of understanding of the hospital is too often matched by the hospital's lack of understanding of the patient. The patient can be greatly helped to understand the hospital by the right procedure at the time of admission. Hospitals which maintain dispensaries should use the dispensary as the means through which patients are admitted to the wards. The provision of a trained and tactful member of the social service department in connection with the admission desk of the dispensary will serve to start many patients, who will later be referred from the dispensary to the wards, with some understanding about hospitals in general and this hospital in particular. From this standpoint, the two critical points in the patient's hospital career are the day of admission and the time of or just before discharge.

A considerable portion of patients are sent to the hospitals by charitable societies. On the Survey census days, it appeared that an average total of 201 patients, or 11.8 per cent. of all patients, had been admitted to hospitals at the request of some charitable agency. In the case of these patients, the charitable society stands to the hospital as an interested party. If its work with the patient and with the family is to be successful, it may need to know the physical condition of the patient, and the prognosis. It

is the duty of the hospital to cooperate with the charitable society by furnishing the necessary information, consistent with the interests of the individual patient.

The hospitals have not always met this responsibility completely or wisely, because of the same deficiency just mentioned, lack of a definite sense of responsibility for interpreting the hospital's work, and failure to assign a sufficiently trained and responsible person to the task.

A considerable portion of the patients in some institutions come as industrial accident cases, or are sent through a medical department conducted at some commercial or manufacturing establishment. The special report of the Survey on industrial medicine and hygiene (Part VII), deals with this matter, but in an industrial community like Cleveland its importance justifies mention here. The hospitals need to serve industry, and industry should support the hospitals adequately in return for service.

What can the hospital do in relation to the difficult problem of the foreign-born who do not speak English? The calling in of paid interpreters is financially impossible in most of the smaller hospitals. Moreover, no one interpreter can speak every language and almost any language of western Europe is likely to be called for sometime. Few if any hospitals could afford even one full-time interpreter, or could manage to keep such a functionary busy with the particular patients whose language he could speak. The problem of hospital interpretation cannot be solved by paid interpreters employed by the individual hospitals. The chief practical recommendations to be made are these:

If a hospital and its out-patient department are taken together, a sufficient number of patients speaking a given foreign language or group of related languages might come to the institution on an average day to justify and require the entire time of an interpreter, and the work in the two branches could be adjusted so as not ordinarily to conflict. The use of full-time interpreters, however, doing no other work, must necessarily be limited to very large institutions, such as the new City Hospital will be. Most hospitals which receive patients not speaking English should solve the problem of interpretation by depending on specially trained nurses or social workers or by calling in the aid of outside organizations interested in the foreign-born or of the foreign-born themselves. Hospital superintendents in engaging employes for certain positions should consider ability to speak certain foreign languages as an asset and a reason for the engaging of a particular individual. Really good interpretation in securing medical and social histories and in meeting the patient's human needs while in the hospital, cannot be obtained by calling in an uneducated orderly. The main reliance should be upon nurses and members of the social service department who have a definite professional sense of responsibility for the hospital patients.

In communities having a considerable number of foreign-born of any one race group, cooperation can usually be obtained from immigrant organizations themselves. These organizations should be encouraged to serve as

visitors to patients of their own race who have not other friends and in helping with the more difficult and special cases in which interpretation is necessary and beyond the power of any employe of the hospital. Enough hospitals are now utilizing outside cooperation of this sort sufficiently to show that it is gladly provided by immigrant organizations (or by American immigrant welfare societies where they exist) without cost to the hospital and to the mutual benefit of both sides. Such an arrangement with immigrant organizations would go a long way toward promoting general understanding of the hospital by the people of that group in the community.

These plans, however, cannot be effective unless some department of the hospital and ultimately some individual is definitely charged with organizing and keeping up the system of interpretation. Generally speaking, the social service department should be charged with this responsibility and some member of the staff of the department should be selected to carry out the responsibility who is especially qualified and interested. A hospital which has any considerable proportion of foreign-born patients should make a point of having in its social service department someone who is able to speak at least one of the foreign languages common among patients and who has secured special knowledge and training in the backgrounds and characteristics of several immigrant groups so that she is capable of fulfilling these duties. This will involve some inside work with various hospital employes, particularly nurses and other members of the social service department; the use of phrase books; the encouragement of various means by which nurses and social workers may secure knowledge about the backgrounds and characteristics of the chief immigrant groups. An effort should be made to interest internes in the same, and this should have the support not only of the hospital superintendent but of the chiefs of the medical staff. It should be made apparent that thus better histories can be obtained, better cooperation of the patient secured, and better medical results achieved.

The critical moment for the patient, from the standpoint of disease, is often the time of admission to the hospital, but the critical time for the patient from his standpoint as a person is usually at or a little before discharge. In the discussion of the problem of convalescent care (page 000) will be found statistics indicating that a large majority of hospital patients leave the hospital needing some definite form of medical care, either in their homes, in a dispensary, or in an institution for convalescents. The information gathered in Cleveland agrees entirely with the studies and estimates of Dr. Frederic Brush, the leading national authority on convalescent care, that the medical job is not done at the time the patient leaves the hospital. The hospital's responsibility as a hospital is not always to do this medical job, but it must link the patient with the physician, the dispensary, the convalescent home, or other organization which will perform the needed service.

The beginning of this connection is the explanation to the patient (or to his parents, if the patient is a child) of the patient's condition, in terms that will be understood by the lay mind; of what need exists, if any, for further medical supervision; or of what daily routine of diet, hygiene,

exercise, and occupation is desirable during the period after discharge. Explanation to the patient or to those responsible for the patient, of the patient's condition on discharge and what may be called the needed program for after-care, is a definite responsibility which few hospitals in Cleveland have met, save in exceptional instances. It is part of the hospital's responsibility to have a definite system for meeting this need.

At a few hospitals there has been established a so-called follow-up system, usually modeled upon that of the American College of Surgeons. This aims to secure for the medical staff the results of operations or the condition of the patient at a certain period after discharge, such as three months, six months, or a year. Such information is of medical value to the staff, and in the long run will tend to the advancement of medical science and the improvement of service to patients. But the term "fish-up" instead of "follow-up" should be applied to a method which merely secures facts as to a patient's condition a certain time after he is discharged, and does not in some definite and effective way help to make the conditions during this period what they should be. A follow-up and not a fish-up system is the standard which should be set in a progressive community like Cleveland, which wishes to obtain 100 per cent. value from the medical work of the institutions which it supports.

When it is found that six per cent. of 200 patients recently discharged from four of the leading hospitals needed continued hospital care—in other words, had relapsed since their discharge; when it is found that 12.5 per cent., in addition, were living under such home conditions that satisfactory convalescence was unlikely (See Table VII., Appendix), it is apparent that expensive hospital service is easily wasted because of the lack of a little further service which would have made all the preceding work permanently worth while.

"Should the social service department have the responsibility for the problem of after-care?" No! The medical staff of a hospital have the responsibility for the care of its patients, and making a medical program for after-care is a part of that responsibility which cannot rightly or effectively be delegated. When it comes to carrying out the details of the work, the social service department has a definite place, as will be brought out more fully later in discussing this subject. The social service department can assist the staff of the hospital in securing the facts regarding the patient's personality, family housing, home conditions, neighborhood, and finances, which in conjunction with the medical facts known regarding the patient's condition, will enable the responsible member of the staff to formulate a program for after-care. When it comes to assisting in carrying out the program, the social service department generally has been and usually should be called in, either to make explanations to the patient or to arrange for contact with the Visiting Nurse Association, the Department of Health nurses or a charitable society which will be able to exercise supervision, to assist in improving home conditions or in securing the institutional care that may be required.

As the facts in the section on convalescence bring out, the need for financial aid during after-care is approximately much less frequent than the

need for explanation and advice, given in terms of the patient's degree of education and understanding, and of the practical conditions of his environment.

The dispensary attached to the hospital should be used as one of the means of providing after-care of discharged patients. Reference of the patient to the dispensary should be made in every instance where further supervision is necessary and the patient cannot pay a private physician. The follow-up system should insure the actual return of the patient to the dispensary in a large majority of instances.

In summary, the patient's lack of understanding of the hospital needs to be overcome by development of the admission procedure, which should be concerned with more than the elementary procedure of registration, assignment to a definite ward or room, and fixation or remission of fees, and which should include educational and interpretative elements. The special problem of the non-English speaking foreigner should be met at the time of admission, and later through some definite provision for interpretation, both by hospital personnel and through the cooperation of associations interested in immigrants, as above suggested.

The utilization of the dispensary as the place of admission for ward patients will, if the dispensary admission system is rightly organized and its personnel rightly selected, enable the average ward patient to go into a hospital bed with some previous understanding of the situation.

The hospital has a definite responsibility for interpreting the patient's condition to him or to those responsible for him, in terms which can be understood by laymen and which will be a practical help; also of explaining and of helping (at least in the beginning) in the needed program for medical after-care. This is part of the medical responsibility of the hospital, and while a social service department is of great assistance both in securing facts regarding the patient's personality and environment, and in helping to carry out the medical after-care or referring the patient to an agency which will do so, a hospital which has no social service department should still be responsible and be able actually to provide for at least the explanation to the patient or his relatives, and the definite reference of the patient to the needed sources of after-care.

The medical staff of the hospital, through its executive committee, should be expected to define the duty of the hospital in this respect, so the administrators of the hospital can have medical authority behind them for seeing that this responsibility is carried out by visiting and resident staff, nursing and administrative assistants, and by the social service department if there is one.

Answering inquiries regarding patients is a definite part of the hospital's duty to the community and should be fulfilled according to a definite cooperative policy by carefully instructed members of the hospital's administrative personnel. Cooperation with charitable agencies in behalf of their patients is a particularly significant responsibility of the hospital, affecting no inconsiderable proportion of the ward patients.

In the long run, the degree of support of the hospitals of Cleveland will depend upon the degree to which their work is appreciated by the community. The elaborate facilities, equipment, staff, and organization needed for the thorough study and treatment of hospital cases require an increasingly high degree of appreciation on the part of the community of just what hospital work is, what it requires, and what it costs. The foundation of appreciation is understanding. Anyone grasps the beneficent service of a hospital to the emergency accident patient, but understanding of the less obvious and more typical cases, which constitute the large majority of patients, is not so easy. The patient's lack of understanding of the hospital is pardonable at the time of entrance. The patient's lack of understanding of the hospital at the time of discharge is a misfortune to the patient and to the hospital as well. Only on the basis of mutual understanding can adequate support for the best hospital work be built up and maintained in Cleveland.

THE MEDICAL PROFESSION AND THE HOSPITALS

In the City of Cleveland the American Medical Directory of 1918 gives a list of 1,169 physicians, of whom 1,050 are stated to be in active practice. A tabulation of the staff lists of the members of the Hospital Council showed that 309, or 29 per cent. of the total were on the staff of a hospital or dispensary, while 71 per cent. had no such connection. Allowing for the small number of additional physicians on the staffs of the non-council hospitals, it is certainly true that two-thirds of the medical profession appear to have no connection with organized medical service.

A similar comparison made about five years ago in Boston indicated that the proportion of physicians having a hospital or dispensary connection was about 50 per cent. larger. In New York, figures collected by the Public Health Committee of the Academy of Medicine indicated that almost exactly 50 per cent. of the medical profession in New York were on hospital or dispensary staffs. Cleveland thus has relatively more physicians than either of these two cities who are not members of any hospital or dispensary organization.

It is apparent that so far as membership on a hospital staff implies advantages for the scientific study of disease, for the use of special equipment, and for consultation with specialists, the majority of physicians of Cleveland have not these advantages. So far as membership on hospital staff gives control in the use of hospital facilities, tabulation of the Cleveland hospitals by number of beds and size of staff shows that about 25 per cent. of the medical profession have control of about 80 per cent. of the hospital beds.

A patient may of course be admitted to a hospital at which his private physician is not a member of the staff, but if the patient is a ward case, the physician then loses the right to treat him. General complaint was made to the Survey during the first months of its work by physicians who were not on hospital staffs, that they often could not secure admission of their patients to hospitals even as private cases, and of course they also complained of the many instances in which the patients were admitted to wards, when the care of the patients had to be resigned to the members of the regular hospital staff.

A study of the sources from which patients were admitted to hospitals on the two Survey census days showed the following:

Request for Admission	Percentage
By staff physician	51.3%
By non-staff physician	33.2%
By charitable or relief agency	11.8%
Source not stated	3.7%

Note—In this tabulation City Hospital, Warrensville Tuberculosis Sanatorium, and Rainbow Hospital are omitted, as admissions at these institutions are on a different basis from those at general hospitals.

These figures appear to indicate that a considerable number of physicians not members of the hospital staffs may and do send their patients to the hospitals and treat them as private cases. It is quite evident, however, that a large number of the 1,050 practising physicians in Cleveland have little if any contact with the hospitals even in this way.

There are wide variations shown in the proportion of patients admitted through non-staff physicians. The variation depends less on the size of the hospital than on the number and organization of its regular attending staff. Thus some of the small hospitals have relatively large staffs, and physicians not members thereof apparently rarely secure admission for their patients. On the other hand, some hospitals of similar size showed on the census days a high percentage of patients admitted by non-staff physicians—proportions ranging up to 83 per cent.

Figures for a group of large general hospitals may be of interest, as showing the wide variation found. These are shown in Table V. in the Appendix.

Part-pay and free cases may be admitted through non-staff physicians, but are rarely treated by other than members of the regular staff. In the group of pay patients, on the other hand, there are a considerable number of private patients among the cases which are admitted through non-staff physicians and who then usually remain under their care.

It must be recalled that these percentages relate only to the two census days, but there is reason to believe that the figures are representative of the usual relationships between the patients admitted through members of the staff and those admitted through non-staff physicians.

The general attitude of a hospital toward the non-members of the staff is expressed by its admission policy. Most hospitals receive private patients and most hospitals have a rule that such patients are accepted, when vacancies exist, from any reputable physician. In practice, however, it is reasonable and inevitable that the members of the officially appointed attending staff have the closest contact with the hospital and are likely to fill a considerable proportion of its beds. When such shortage of beds exists as in Cleveland, the difficulty felt by many physicians not on hospital staffs in securing admission of their private patients is not more than may be expected. There has been no substantial evidence that the administration of the hospitals, year in and year out, has been unduly inconsiderate of the private physician of good standing who sought admission for his patient. Members of the official staff have received reasonable preference but this is only natural. Until more beds are available for private patients of physicians in privately-supported hospitals, present conditions cannot be expected to be radically improved.

In a few institutions there has been found a practice, not formally recognized by rule, but real nevertheless—of holding beds vacant twenty-four hours or even more because certain members of the staff were likely to wish

to send patients in. A practice of this kind is unjustifiable, but is exceptional in Cleveland.

A study of the degree to which members of hospital staffs overlap revealed the fact that, except in the teaching institutions affiliated with Western Reserve University Medical School, there is no large degree of multiple membership on hospital staffs. Even in the case of University teaching at Lakeside, City, and St. Vincent's Hospitals, there is little actual overlapping of the staffs. The number of men holding positions in the staffs in one or more hospitals in Cleveland is shown in the following table:

MULTIPLE MEMBERSHIP ON HOSPITAL STAFFS

233	physicians,	or	22.2%	of	total	number,	serve	on	1	hospital	staff
55	"	"	5.2%	"	"	"	"	"	2	"	staffs
15	"	"	1.4%	"	"	"	"	"	3	"	"
5	"	"	0.5%	"	"	"	"	"	4	"	"
1	"	"	0.9%	"	"	"	"	"	5	"	"

These memberships, however, include some inactive as well as active memberships. In general, active membership in more than one hospital staff is not wise, except in the case of multiple membership held for teaching purposes or in the case of men who are engaged in restricted specialties of medicine or surgery and can render these special services to a number of institutions with benefit to all. Of the 42 members of the City Hospital staff, 26 are nominally active members of other hospital staffs. This, however, is a teaching institution. The instances in which a physician is carrying several active memberships in hospital staffs in Cleveland are proportionately small. Some of these individual instances, however, are worthy of notice, and the Survey, in its reports to the several boards of trustees, has called them to the attention of the individual hospitals concerned. A position involving active service in one hospital ought to be sufficient for a physician and it is wiser for his attention to be concentrated on this institution than to be divided among several. Multiple membership, therefore, with the exceptions noted, should be discouraged.

In connection with Western Reserve Medical School, the following figures are of interest. 331 of the 1,169 listed physicians in Cleveland are graduates of Western Reserve University Medical School—28.3 per cent. of the total. Of the 309 staff positions in the hospitals and dispensaries of Cleveland, 75, or 24.2 per cent. are held by graduates of Western Reserve University Medical School. It will be seen that the proportionate number of positions held by graduates of this medical school is somewhat smaller than the number of graduates of the school among the medical profession as a whole. It should be added that in the hospital and dispensary positions 31 in addition to the 75 just named, are held by members of the medical school faculty who are themselves graduates of other schools. This gives a total of only 106 out of the 309 hospital and dispensary staff positions which are held by graduates or members of the faculty of Western Reserve Medical School.

In connection with the so-called "democratizing" of hospital facilities for the medical profession, it should be pointed out that no hospital can be satisfactorily managed without a definite official staff. A medical boarding house, as previously defined, is merely a nursing home in which physicians treat private patients. Any hospital which endeavors to maintain a medical organization, equipment, and personnel, for diagnosis and treatment, must have some medical authority appointed, to be responsible to its managing body. A number of the proprietary hospitals are maintained by one or more physicians who conduct them as their own enterprises, and who are medically as well as financially responsible. The public service hospital with a board of trustees or other disinterested governing body, must appoint an official attending staff. The functions of this staff are not only the care of patients, excluding such patients as are admitted specifically as private patients of non-staff physicians. Its functions also include the determination and maintenance of the standards of medical practice which shall be observed in the institution. A medical staff of a hospital should not be merely a group of individuals each of whom has a certain ward or number of beds under his charge, for a year or part of a year, but it is or should be an organization—a group of physicians representing different branches of medicine and surgery, organized for the joint practice of medicine with the equipment and facilities provided by the hospital, defining and maintaining the professional standards and policies which shall be effective throughout the institution.

In some hospitals the medical staff does not fulfill these functions adequately. It does not set clearly defined standards which govern the practice of physicians in the institution. Thus in the matter of record keeping, there are a number of hospitals in which fairly accurate and complete records are kept upon ward patients, showing that physical examination was made, laboratory tests performed, and that careful notes were entered at the time of operation or during the course of the patient's treatment. In the same institution, the records of the private patients of physicians may be limited to identifying or financial data, and have almost no medical information of significance. Such a hospital has not maintained (so far as the records show) the same standard of care for private patients as for part-pay or free patients, who come under the charge of the hospital's attending staff without remuneration. Records are not always a complete index of the degree of care actually provided, yet there can be no doubt that particularly in the matter of laboratory tests and consultation with specialists, part-pay and free cases in many hospitals receive more thorough study than do many private patients. Greater privacy and more intimate personal relation of the patient to the family physician are maintained for the private case as a possible counter-balance.

In proportion as the general public and trustees of hospitals appreciate that a modern hospital should not be a medical boarding house in whole or in part, but a medical organization in which the best resources which the hospital has to offer in equipment or personnel should be made available for every patient in so far as he needs them, hospital organizations and hospital procedures will be uniform for all classes of patients, private, part-pay, and free. Patients and physicians alike will profit by such a policy.

With these principles in mind, there have been appended to this chapter certain details which supplement the general principles of hospital organization stated in the section on Organization for Service.

The organization of the medical executive committee is for the purposes (*a*) of providing the medical staff with a small group which will enable it to conduct the routine business of its organization, formulate hospital standards and policies, and make arrangements for the monthly staff meetings; and (*b*) of providing a group for regular conferences with the superintendent of the hospital, and, from time to time, conferences with representatives of the board of trustees, to assist in administering the hospital satisfactorily.

The provision of an auxiliary staff is believed important, particularly in view of conditions such as those of Cleveland. It is highly desirable that the number of physicians having some connection with hospital staffs should be increased. On the other hand, it is essential that active attending staffs of every hospital be not so large, in proportion to the number of beds, as to be unwieldy or incoherent. Otherwise standards of service are likely to suffer. The organization of an auxiliary staff provides a means of recognizing in a definite way physicians who are utilizing the institution for their private patients or for consultation purposes, and for giving such physicians a definite channel through their delegates whereby they can express themselves to the official staff or to the hospital trustees.

Beyond such machinery of organization, other means exist for opening the facilities of Cleveland hospitals and dispensaries to a larger proportion of the medical profession. It is not only in connection with the surgical operation upon a patient, but also in the medical treatment of acute cases, that physicians need the advantages of the diagnostic equipment of hospitals and dispensaries, and of the skill of specialists on their staffs. The laboratory, the X-Ray department and other diagnostic equipment, and the service of specialists need to be utilized by the private physician in behalf of his patient. To make the splendid equipment and personnel of Cleveland hospitals available for diagnostic purposes to the medical profession of Cleveland on a large scale is one of the chief goals to be sought for. This must be worked out in practice largely through the increase of dispensary service in the form of diagnostic clinics, to be available for consultation purposes for non-staff physicians. More detailed reference to this is made in the succeeding chapters on dispensaries.

The enlargement of dispensary service which Cleveland so greatly needs would provide opportunity for a considerable number of physicians to come into close contact with hospital work, as dispensary staffs should be organized in intimate relation with hospital staffs. (See page 846.) The medical advantages of facilities for diagnosis, of consultation, and in general, of intimate contact and co-working with other progressive physicians could be opened to a very large number of physicians not now on the staffs of Cleveland medical institutions. The approximate proportion of physicians connected with hospitals and dispensaries in Cleveland ought surely not to be less than in New York (about 50 per cent.) which would mean the addition of 200 or 250 physicians to the staffs. If dispensary service in Cleveland

is developed as it should be during the next few years, this result may be measurably achieved.

There are certain groups in the medical profession who feel that their opportunities in the medical institutions of the city are specially limited.

Interviews with a number of foreign-born physicians revealed a considerable feeling that they "hadn't had a chance." A list of 63 foreign-born physicians in Cleveland, furnished by one of the organizations interested in immigrants, is probably considerably less than the actual number. Many of these physicians have a large practice among groups of immigrants and their children, who constitute a considerable proportion of the population of Cleveland. Only nine of these 63 physicians were found to be on the lists of any of the hospital staffs. The foreign-born physicians of the more recent groups of immigrants, such as the Slavic and Italian peoples, are practically unrepresented. It may be felt by many that such a condition will tend to take care of itself with time. However, the unstimulated movement of "time" is too slow. A definite effort should be made to give recognition on hospital or dispensary staffs to physicians of good standing who are of foreign birth or descent, particularly in institutions which number among their patients large numbers of the foreign-born. As has appeared in the section discussing "The Human Problem of the Hospital Patient," (pages 849–857), a number of the hospitals fall into this group. There is unusual value in dispensary service rendered by well-selected physicians of this type.

Physicians of the Negro race constitute a small but definite group whose opportunities to work in medical institutions of Cleveland have been greatly restricted. There are said to be 19 Negro physicians in Cleveland. One of these men is on the dispensary staff of Lakeside Hospital. Representations made to the Survey by physicians and laymen of standing among the colored people of Cleveland are to the effect that the negro physicians and the negro people feel the deprivation brought about by lack of membership on the staffs of hospitals and dispensaries. The problem can be dealt with only in one way, by determining that appointments shall be based solely upon merit. It is a fine testimony to the spirit and policy of the hospitals of Cleveland that so far as negro patients are concerned, there has been absolutely no complaint by the Negroes about discrimination. The establishment of a special hospital for colored people is believed to be unnecessary and undesirable.

Perhaps the most important relation of hospital and dispensary to the medical profession is their educational function. The hospital and dispensary represent to the physician an opportunity to raise the practice of medicine to a higher power because they bring under his command the use of equipment, the organized professional skill of specialists, and technical assistance such as are very rarely available in private practice, and then only to the rich.

The educational function of the hospital and dispensary is only in part exercised through medical schools. The teaching of a medical school like that of Western Reserve University depends in a large measure upon the

hospitals and dispensaries which are affiliated with the school. Undergraduate teaching is and in general can most advantageously be limited to a few selected hospitals. The development of post-graduate instruction under the medical school in the general and special branches should proceed at a rapid rate in the near future, and should involve the use of a considerable additional number of hospitals and clinics.

The actual value of the hospital as a place of advancing medical science and of the skill of the local profession depends of course largely upon the use made of the advantages offered. Decidedly one of the most important means of self-criticism which a member of a hospital staff can have is the autopsy. Definite knowledge concerning the disease which caused the death of a patient can very frequently be obtained by autopsy as in no other way. It is disappointing to find that according to reports received by the Hospital Council during the year 1919, only 456 autopsies were performed. Reports from some hospitals were a little indefinite, and the true number might have been slightly larger. The figures and details are shown in the following table.

AUTOPSIES PERFORMED IN 1919 IN CERTAIN HOSPITALS

City	(approximately) 209	Mt. Sinai	50
Fairview	0	Provident	0
Glenville	1	St. Alexis	number unknown
Grace	number unknown	St. Ann's	20
Huron Road	5	St. Clair	1
Lakeside	110	St. John's	20
Lakewood	number unknown	St. Luke's	5
Lutheran	0	St. Vincent's	27
Maternity	8	Woman's	0
Total			456

Such a low percentage can only mean one of two things—either failure on the part of the medical staff to appreciate the importance of autopsies, as a real checking up of results, and setting a real standard of self-criticism and self-improvement, or on the other hand, a lamentable deficiency in administration, in failing to endeavor, in each case of death, to secure if possible consent for autopsy from the family of the patient. Experience in many hospitals in other communities shows that it is necessary to fix responsibility upon some definite person for each branch of service, usually on the senior resident or interne, for securing permission. Compliance with the spirit as well as with the form of the standards of the American College of Surgeons demands that the medical profession for its own sake show better results in the future in securing autopsies in the hospitals of Cleveland. It is recognized that the public needs education to understand the great value of autopsies, not only for the physician, but in the long run to improve the treatment of every patient.

It is particularly interesting to observe that the three teaching hospitals (City, Lakeside, and St. Vincent's), together with Mount Sinai, show 396 autopsies out of a total of 456. Taking these four hospitals, the number of autopsies compared with the number of deaths is shown in the following table. It will be observed that the best showing made is of only about one-third of deaths autopsied, and that the average even of these hospitals i s less than 25 per cent.

AUTOPSIES AND DEATHS, COMPARED, 1919, IN FOUR HOSPITALS

	Autopsies	Deaths	Percentage of autopsies to deaths
City	209	861	24.3
Lakeside	110	320	34.4
Mt. Sinai	50	188	27.1
St. Vincent's	27	331	8.2
Totals	396	1,700	23.3

Beyond the formal courses recognized as such under the medical school, however, the broader educational function of the hospital and dispensary ought to be fulfilled. Monthly staff meetings for the discussion of cases, review of hospital statistics, and of the result of operation or treatment, are valuable means whereby the physician and the hospital are stimulated, and the service of the institution is advanced. The participation of an auxiliary staff should be of much educational value. The daily contact of physicians with one another in the clinics of the dispensary and in the wards is a less formal but no less effective means for development of knowledge and skill. Finally, the opening of facilities for diagnostic service to the physicians of a community on a broad scale, through diagnostic clinics, and larger provision for treatment of private patients, should serve to render the medical educational functions of the hospitals and dispensaries effective over a much wider range and to a more profound degree.

MEDICAL STAFF ORGANIZATION*

(a) The members of the Medical Executive Committee should include the chiefs or representatives of the division of medicine and surgery, one or more representatives of the specialties, and a representative from the assistants or junior members of the staff.

(b) The Medical Staff should establish standards of hospital practice in all departments, including laboratories, X-Ray department, etc. All Medical Staffs should take official action by resolution or pledge in the matter of fee splitting. No member of the Medical Staff should hold membership on the Board of Trustees. Privately organized hospitals with

*By W. L. Babcock, M. D. Reference should be made to pages 845-848, to which this is a supplement.

Boards of Trustees consisting of medical men should reorganize by arranging for the appointment of a lay Board of Trustees, the physicians interested in the hospital organizing into an Attending Staff. The senior Attending Staff physicians should hold active staff membership in one hospital only. This restriction should not apply to members of the staff engaged in university teaching, or to specialists with limited services, or in small hospitals to clinical assistants.

(c) The following additional committees will often be found useful:

Library Committee.

Resident House Staff Committee.

Hospital Records or Program Committees.

(d) Provisions should be made for the recognition of non-staff physicians by permitting the use of a limited number of hospital beds under the general supervision of the Chief of the Medical Staff through Chiefs of Departments. It should be recognized that the so-called open hospital is a powerful factor in preventive medicine, a post-graduate school for the general practitioner, and a great influence towards his professional elevation. The practice of non-staff physicians in hospitals should be regulated, scrutinized and carefully supervised by the Executive Committee.

(e) The stand taken by the Cleveland Hospital Council to the effect that all hospital bills should be paid before the Attending Physician or Surgeon collects his bill is to be commended and should be made a rule in every hospital.

(f) At least ten staff meetings should be held annually, at monthly intervals, excluding July and August. As many more may be called as are deemed necessary. The Executive Committee should meet monthly or oftener. Regular Staff Meetings should be 90 per cent. clinical. Routine business should be abbreviated and parliamentary discussions avoided, except on important matters of staff or hospital policies. Provision should be made by the Record Committee, or otherwise, for review of clinical records. Reports of unusual or interesting cases should be presented for group discussion, together with results of original research work carried out by individual members of the staff, or the hospital laboratories. It is also desirable that arrangements be made to serve light refreshments after these staff meetings, which must, of necessity, be held in the evening. It has been shown in at least one instance where this program has been carried out for years that the percentage of staff attendance has averaged 75 to 80 per cent.

of staff membership and has exceeded, by several hundred per cent., the attendance at regular meetings of the County Medical Society. Attention is called to the recommendations of the American College of Surgeons as to program for staff meetings. The Associate, Auxiliary and Resident Staffs should meet with the Attending Staff at their monthly clinical meetings.

FINANCES AND ADMINISTRATION

To maintain the 21 institutions which are members of the Cleveland Hospital Council cost nearly three million dollars during 1919. About 97 per cent. of this was for hospital care and 2½ to 3 per cent. for dispensary service.* This $3,000,000 represents about 700,000 days of hospital care given, and 120,000 dispensary visits. It represents service to probably 80,000 different individuals. In other words, these hospitals and dispensaries care for one person out of every twelve in the population of greater Cleveland, and cost about $3.07 for each member of the population. Only a fraction of this cost, however, is a net charge upon the community, for as the third column of Table VI. indicates, the operations of the institutions yielded a very considerable portion of the necessary income.

Over two-thirds, in fact, of the expense of the non-municipal hospitals is repaid by fees from patients and by other earnings. The other third, or between $600,000 and $650,000, has to be provided by interest on endowments, by legacies and gifts from the public. Taxation must provide for the municipal institutions to approximately the same amount. It will be observed that in these figures relating earnings to expenditure, only the non-municipal hospitals are considered. While there are some earnings in the municipal institutions, they cannot fairly be compared with the other hospitals in this respect.

The non-municipal hospitals bring upon the public an annual charge of approximately $460,000, after deducting from the total expense the earnings from patients and the amount available from endowments of various sorts. This figure is the estimate for the year 1920, as presented to the public in the Community Chest campaign of November, 1919. The City Hospital, together with Warrensville Tuberculosis Sanatorium, required in 1919 an appropriation of $625,656.92 from taxation. Adding together the cost for the municipal and the non-municipal hospitals, we find that $1,086,000 is the approximate amount required to maintain the hospitals and dispensaries of Cleveland, in annual contributions by the public or "voluntary" taxation, taken together with legal or compulsory taxation. This is about $1.30 for every man, woman, and child in the city of Cleveland, or about $1.10 per head if the larger metropolitan area which these hospitals serve is taken into consideration.

Parenthetically, it should be noted that these figures do not include the cost of the dispensary "Health Centers" maintained by the Division of Health, the cost of the city physicians who care for the sick in their homes, or any of the other expenses of the Division of Health. In the main, the bulk of these vast sums goes for the care of sickness. The total amount expended for education in hygiene and for the prevention of disease is only a fraction of this amount, the expenditure for the Division of Health being less than 50 cents per capita. Expenditures for hospitals are necessary

*The cost of the dispensaries is not accurately stated in several of the hospital reports, and the above figure is therefore an estimate, merely.

and desirable under present conditions, but one may look forward to a day when the proportion between the expenditure to cure illness and expenditure for prevention will not be so heavily weighted against the preventive measures.

The cost of hospital service is more accurately expressed in terms of the unit previously defined; namely: average cost per day of care. As will be seen at the foot of Table VI., this average cost for a large group of the non-municipal hospitals was approximately $4.39 in 1919.

Hospitals have felt keenly the high cost of living, more heavily in fact than most institutions, because of the large proportion of their expenditure which goes for food, drugs, and supplies of all kinds, which have especially increased in price during the past few years. The public has not appreciated how expensive good hospital service must now be.

When individual hospitals are compared, the average cost stated in their reports for the year 1919 varied from $2.00 to $5.62. This range is doubtless too wide, in that it is not believed the lower rate is a true representation of the cost of any hospital. Accounting systems have not always been designed so as to charge to annual maintenance all the items which should properly be so entered. It is not believed at the present time that any member of the Hospital Council is maintaining service at a rate less than $3.00 per diem, and this figure is too low to render adequate service under present conditions. A general hospital properly equipped should expect a per capita cost of fully $4.00 per diem. When a hospital is rendering an unusual grade of service or is conducting medical teaching or research, a cost of $5.00 a day need not excite objection.

In general, the average cost of a day's care, or the so-called "hospital per capita," must be used with great caution as a basis for either commendation or criticism. It must be known how the per capita cost is made up—whether for instance a low per capita is due to undue crowding, whether a high per capita has been due to a small number of bed days care given because of temporary lack of demand or enforced closing of certain wards or rooms, or whether a high per capita is due to unusual quality of service, or on the other hand to uneconomical administration, or again whether a low figure may be accounted for by careful, economical administration, or else by the lack of the proper facilities.

As a rule, many different elements must be known and considered before forming any judgment as to the significance of a given per capita cost. The average for the city as a whole is of considerable general interest, particularly in view of the need to call public attention to the expensiveness of modern hospital service. The fact that hospitals have been generally charging ward rates (at least until very recently) as low as $2.00 per diem is a little misleading. The average person has somehow taken for granted that if a patient paid the so-called ward rate, the hospital's cost was met. This is far from the truth. Ward rates have generally been put far below cost, and in recent years, most of the hospitals of Cleveland have failed to raise ward rates to correspond with the increase in expense. This has been

due in considerable measure to a desire not to levy a tax upon the sick and suffering, or to make known rates which might keep needy patients from the hospital doors.

Time was when hospitals were thought of as charities for the destitute, but at the present time, hospitals are public services receiving the well-to-do and middle classes as well as the poor, in varying proportions. The general public should be brought to the point of understanding that hospital service ought to be paid for at its cost by those who are able to pay, and that room and ward rates should be adjusted with respect to cost of service. Considering the fact that a hospital of the public service class often has an endowment, it should be expected that the income from the endowment will go to help make up the difference between the cost of service and the earnings from operation. A deficiency will be due partly to the fact that the ward rates are put at less than cost, and partly to the fact that many patients should be and are accepted who cannot pay even these rates.

As a general principle, ward rates ought to be fixed somewhat below the cost of service, but not very much below. It is believed wise that at the present time the hospitals of Cleveland should not announce rates for ward service at less than $3.00, and in many hospitals or in some divisions thereof, ward rates may be $3.50 a day. The naming of these rates in no case should imply that patients unable to pay them in part or able to pay nothing should be refused admission. A hospital cannot expect financial support from the public unless it makes the patient's need and not the patient's means the basis on which service is offered and rendered.

In the following section of this Chapter (pages 877–889) Dr. W. L. Babcock has outlined a large number of highly practical suggestions and recommendations regarding administration. Many of these relate to finances. It is only fair to point out that the Cleveland Hospital and Health Survey, despite evident eagerness on the part of all members of the Hospital Council to cooperate, found it no easy matter to secure many of the fundamental financial and statistical figures from a number of hospitals. There was nowhere lack of willingness, but the accounts had not been kept with a view to critical self-analysis.

Methods of hospital cost accounting have been pretty thoroughly worked out during recent years. Many smaller hospitals feel that they cannot readily maintain the trained book-keeping staff to carry out a cost accounting system. The extra time required by such a system and the extra expense involved seem too much, and the hospital is likely to go without. In the long run, good cost accounting is a money saving enterprise. It points the way to more economies than its own maintenance costs. It also helps in fixing rates so that they bear proper relation to cost, and tends to increase income where income needs to be increased.

The needs of the smaller hospitals can be met only by some cooperative enterprise. The Welfare Federation should establish an expert accountant service, available to any of the Cleveland Hospital Council members, for

service in the administration of proper accounting systems and for advice periodically or whenever necessary in its maintenance. Such a plan would make available to all hospitals a grade of accountant service which few if any could afford to maintain alone. The plan would have the further great advantage of enabling uniform financial reports to be periodically rendered to the individual boards of trustees, to the central budget-making authorities of the Welfare Federation and to the public, which in the long run foots the bills.

In matters of financial as well as medical service, trustees need to determine exactly what figures they need to have presented to them in their annual or monthly reports, in order that they shall know all they need to know regarding the work of the hospital. The central accounting system proposed would be of great constructive value to every board of trustees, not only in furnishing information, but in helping them to see what information they need to have furnished. An X-Ray department, for instance, is very expensive to maintain in terms of gross expense, but in many hospitals a considerable proportion of the X-Ray work is for patients who can pay a fair fee, so that the net expense of maintaining the department is not large. In a hospital doing a large proportion of its work for patients who can pay few if any fees, conditions are different, but in any hospital, proper accounting will show just what the X-Ray department costs, just what ratio the income derived from it in its different classes of work bears to the expense thereof, and the trustees will be able to judge at the end of a month or a year how much net charge this service brings according to the character of work and service rendered, and the rates which patients can reasonably be expected to pay.

Perhaps the most fundamental need for trustees is to appreciate that hospitals are public services in the broad sense of the word. Two more or less opposite conceptions have dominated hospitals: (1) that represented in its extreme form by the proprietary hospital treating private patients where financial return from the patient is largely used in determining his acceptability, (2) the charitable corporation in the old sense of the term, according to which hospitals are regarded as rendering benefits to the helpless who neither can or should be expected to make any financial return. At these two extremes we would find hospitals serving private patients only, and hospitals serving only the poverty stricken and the destitute. The outstanding development in the relation of hospitals to the community during the last decade or so has been the increase in hospital demand by persons of the middle classes, the self-supporting families of moderate means in fairly comfortable financial condition but with no large property holdings and no large annual margin of income over expenditure. These so-called middle classes are more and more finding that it is better to go to the hospital than to be treated at home in serious illness, surgical operation, or for maternity care.

Much testimony has been received in Cleveland that there is great demand for beds for these middle classes. Beds are demanded in private rooms or more particularly in two to four-bed rooms or small wards, where fees

will be moderate and service excellent but not of what may be called the exclusive type.

The hospitals of Cleveland face such large financial obligations in view of the high cost of living that much anxiety has been felt by many trustees in looking forward to the future. Generous public support for the hospitals through the Community Fund or in other ways is indeed necessary, but the enlargement of the hospital facilities of Cleveland, particularly in providing more fully for the middle classes, will assist the hospitals financially by rendering a larger proportion of their services of a self-supporting nature, and thus help in carrying a general overhead which in itself is a very considerable part of modern hospital expenditure.

The Cleveland Hospital Council is to be congratulated for having recently secured from the Industrial Commission of Ohio, a more satisfactory recognition of the hospital's service to industrial accident cases. In Ohio, as in many other states, the establishment of workmen's compensation took place without adequate recognition of the large part that hospitals and dispensaries would need to play in its successful administration. Industries and insurance companies found that prompt and competent medical assistance to men who had met with industrial accidents was not only humane but was good business. The promptest possible return of the employe to his work stops the weekly payments and saves more money than it costs. There are no theoretical or practical reasons why hospitals which are supported by the community as public service enterprises should render any service to industry for less than the service costs, when under the very foundation principles of workmen's compensation, the industry is supposed to be paying the full amount of the bill for industrial accidents.*

Hospitals supported by the community must necessarily receive and care for many patients who are properly public charges of the city or county or of some other county. It is fair and desirable that hospitals be reimbursed for the care given patients who are proper charges upon the public. Since the city of Cleveland maintains its own hospital, the City Hospital is naturally the first place to which such patients should be sent, but because of emergency or other reasons, other hospitals will necessarily receive cases which are charges upon the city or county. The law as recently amended renders it proper for the Commissioners of Cuyahoga County to reimburse institutions furnishing care to persons who are public charges.† It is believed that the following principles should govern the administration of this provision:

1. A policy of paying privately owned and supported institutions for services such as the care of the dependent sick, which is a public function and a means of preventing disease and dependency, instead of providing adequate, publicly owned and operated hospitals out of the general tax rate of the city, is essentially unsound and should be condemned as

*Through the efforts of the Hospital Council the State Commission adopted the principle of "hospital cost for service rendered" on July 1, 1920.

†The Hospital Council has already negotiated with the County Commissioners on this subject and negotiations are encouraging.

offering temptations to the political use of public monies, and as contrary to the spirit of municipal government.

2. Notable instances of abuse of the practice of subsidizing private hospitals and other privately owned institutions are to be found in the recent history of the state of Pennsylvania. In certain cities, however, notably Detroit, Michigan, and New York City, payment to private institutions for the care of public charges has served a useful purpose and has been honestly administered.

3. Only as a temporary expedient and under strict and exact determination of the quality and quantity of services rendered for which payment is made can such a practice be approved for the city of Cleveland.

4. With the city definitely committed to the construction and maintenance of a modern City Hospital, the facilities now under consideration and agreed to by the private hospitals can confidently be expected, if carried out, to offer relief for approximately the next twenty years on the basis of the estimated growth of Cleveland.

5. Without urging the point to the extent of asking for any public declaration or commitment by the Hospital Council to a policy, it is thought by the Survey that agreement should be reached by the hospitals in the Hospital Council to apply funds for the extension of their facilities for part-pay patients equal in amount to the sums received in the year from the County Commissioners. It is particularly the responsibility and privilege of the privately owned hospitals to meet the need of the patient of modest means who expects to pay part, if not the whole cost of hospital care. County payments for the care of the dependent sick should be a resource for increasing part-pay bed capacity and should not be accepted merely as a relief from the burden of raising funds for meeting current expenses.

6. With the understanding that the full influence of the Hospital Council collectively and through its component institutions will be used to accomplish the two objects mentioned in 4 and 5 above, and in the belief that the necessity for County payments to private hospitals should cease when adequate provision for the dependent sick is made in publicly owned and operated hospital or hospitals, the Survey endorses the proposed system of contracts with the County Commissioners under the following conditions: namely, that payments by the County Commissioners to hospitals with which they make contracts shall be made only for services of an approved quality, provided for a definite period of time and for specified individual patients who have been shown to be entitled to public relief after investigation of their home or economic condition by representatives acting under the orders of the County Commissioners.

7. Inasmuch as the County Commissioners cannot, without amendment of state laws, employ from public funds investigators to ascertain the quality of services given to patients or to verify claims of hospitals and patients that such and such individuals are proper objects of public assistance, it is suggested that the Hospital Council request the Community Fund to put at the disposal of the Welfare Federation such amount from the unassigned funds as may be needed (tentatively estimated as $5,000) to employ trained social investigators to be put at the disposal of the County Commissioners for the purpose above described.

8. It is suggested that the Hospital Council bind its members by mutual agreement to enter into contract with the County Commissioners only on the basis of the conditions suggested in 6.

The hospitals of Cleveland are in a fortunate position compared with those of most cities, because of joint financing through the Community Fund. The needs of many institutions are brought before the public at a single time in a forceful impressive way. Mutual relationship among hospitals and a better understanding of the broad needs of the community are certainly promoted also. None the less does the work of each hospital need interpretation to the public which supports it financially. There is indeed a more definite demand for accurate and comprehensive financial reports under such a system as exists in Cleveland, since the central financial and appropriating committees of the Welfare Federation are in a position to scrutinize the financial reports of each hospital much more closely than the average contributor will in communities wherein each hospital raises its funds independently. An added stimulus is thus applied toward economy and toward careful financial and book-keeping systems. All the more do the hospitals of Cleveland, particularly the smaller ones, need expert accountant service to enable them to work out their book-keeping and their financial reports in the best way.

The Purchasing Bureau of the Cleveland Hospital Council is a distinct and notable achievement, indicative of the spirit of cooperation in community enterprises which is characteristic of Cleveland. Through the Purchasing Bureau more economical and satisfactory buying of standard hospital supplies is made possible. Each member of the Council is thus provided with the services of an expert in buying, who is devoting his entire time to studying markets, making contracts and assisting the hospitals to get the best and the most for their money. It is to be regretted that the use of the Bureau by a number of hospitals has not been as large as it should be. If the purchases of the hospital for all kinds of supplies be taken, and the amount of purchases made in 1919 through the Purchasing Bureau, be expressed as a percentage of this, we have a certain index of the degree to which the hospital has taken advantage of this measure of economy. It is found that the percentages of utilization by the different hospitals were as given in the following table:

PROPORTIONATE USE OF THE CENTRAL PURCHASING BUREAU OF THE CLEVELAND HOSPITAL COUNCIL

Hospital	Proportion of Maximum* Purchasing Possibility
Cleveland Maternity	2/3
Fairview Park	Less than 1/3
Glenville	Approximately 4/7
Grace	1/6
Huron Road	1/8
Lakeside	Maximum
Lakewood	1/13
Lutheran	1/25
Mount Sinai	Less than 1/3
Provident	1/12
St. Alexis	1/20
St. Ann's	3/8
St. Clair	1/5
St. John's	1/5
St. Luke's	About 1/4
St. Vincent's	1/17
Woman's	Approximately 1/5

Most hospitals find it convenient to make some purchases independently from time to time, because of the unusual character of the article to be bought or because of the haste with which it must be secured, but given efficiency on the part of the Purchasing Bureau, these objections should be reduced to a minimum. Furthermore, it is obvious that the more fully the Bureau is utilized, the larger will be its purchasing power and the better terms it can make. Doctor Babcock's recommendations regarding the Bureau (pages 882–885) are very pertinent and practical.

In this as in helping the hospitals to save money by getting the largest discounts for cash (page 879—section on "Practical Matters of Administration") the Welfare Federation is in a position to make the money contributed by the public go further than it now does.

Hospitals are likely to benefit by taking advantage of every opportunity for expert assistance in any of their many special lines of activity. The School of Pharmacy of Western Reserve University, for instance, is in a position to offer assistance to the hospitals of Cleveland that would be of great benefit in two ways: enabling the hospital to render a higher type of

*In 1919 Lakeside Hospital made practically all of its purchases, amounting to exactly one-third of its operating expenses, through the Central Purchasing Bureau of the Cleveland Hospital Council. That figure has therefore been adopted as the maximum purchase percentage, and the purchases of other hospitals have been figured on this basis.

service to the public, and lowering the cost of medicines to the hospitals. For a description of the proposed service, see the section on Pharmacy, in Part VIII. Such a plan would take at least a year to perfect, but its value to hospital service should be self-evident.

Hospital financing and hospital administration have become technical matters. At best, the average layman is not concerned with or even interested in their details. It is of the greatest importance, however, that the hospitals of Cleveland shall not lose their individuality because of joint relations through the Welfare Federation and the Cleveland Hospital Council, and that the work of each hospital as well as of all hospitals taken together shall be properly understood by the public. To take technical reports of income, expenditure, and service rendered, as prepared by the hospital for the use of its trustees, the Cleveland Hospital Council, and the Welfare Federation, and to utilize these reports as the basis of an account of hospital work in which the whole community will be interested, is the duty of a "publicity man." The publicity men and the Welfare Federation which provides publicity service, should constantly bear in mind that the public needs to be helped not only to understand what hospitals do, but that their work is costly and why this is so. Comparisons of the present cost of hospital care with the cost in former years will be useful if so presented as to bring home to the reader that the added cost is not only because of higher price levels, but means also a higher quality of service. The business man who thinks in terms of dollars and cents needs to be made to see why the medical boarding house type of institution has a lower cost, and why such low cost is not as good a thing for the community as a hospital costing fifty per cent. more per capita but run as a modern hospital with adequate medical, nursing, and social service facilities for diagnosis and treatment. The public must learn that health can be bought at a price and that the price is worth paying.

SOME PRACTICAL MATTERS OF ADMINISTRATION

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In making these statements and recommendations on General Administration, it is recognized that the Cleveland Hospital Council has had many of them under consideration and in certain instances has actually had committees at work in standardization of supplies, uniform records, accounting, uniform rates, etc. In its contact with the administrative departments of the hospitals within the Council, the Cleveland Hospital Council has developed a working organization of great practical benefit to its members. The projects under consideration by its various committees, as well as the recommendations herein, are practical and logical steps in the development of economical administration and efficiency. The Council would be of little benefit to its membership unless it adopted standards that would tend to lift the level of the hospitals to an efficient average. The Council can be of the greatest benefit if it leads, plans and organizes in advance of the hospitals.

FINANCIAL

1. FINANCIAL AND OFFICE RECORDS, BOOKKEEPING, ETC.—The Cleveland Hospital Council has unified and standardized the financial and statistical reports of its constituent hospitals. The bookkeeping systems, forming the basis of these reports, which are rendered monthly, have not been standardized in the various hospitals. It is recommended that the bookkeeping forms and headings used by the various hospitals be made uniform. This is particularly necessary for cash blotters, and voucher registers, in order to show similarity in distribution of earnings and expenses.

The records furnished the Cleveland Hospital Council relating to per capita cost in some of the hospitals have been fallacious from the beginning for the reason that many of the extraordinary expenses of some of the hospitals have been charged to special funds and not to maintenance accounts. In several of the smaller hospitals record of receipts and expenditures only is maintained. No attempt has been made by these hospitals to credit or debit the various departments of the hospitals with their earnings or expenses. The per capita costs reported by Cleveland hospitals for 1919 varied from $2.00 to $5.62 per day. In order to determine wherein this difference may be found, it is necessary to check earnings and expenses by departments, such as training school, laundry, housekeeping, building maintenance and current repairs, administration, professional care of patients, etc. The latter should be subdivided into its natural subdivisions, such as laboratory, X-Ray department, surgical department, house staff, etc.

2. ACCOUNTING—The monthly and annual accounting for all hospitals should be made by an accountant under the direction of the Welfare Federa-

tion. It may be feasible for the latter organization to maintain the services of a paid accountant staff who could carry on a month-to-month audit in all hospitals within the Federation and furnish each Board of Trustees with a monthly and annual accounting statement. If the recommendations set forth in paragraph 1 are carried out in all of the hospitals, it will simplify the audit and accounting to a great extent. If a uniform system of financial records and bookkeeping is established for each of the hospitals in the Council, the time devoted by auditors on the books of some of the hospitals could be reduced 50 per cent. or more. It should be stated here that the Welfare Federation has provided for these audits heretofore through a firm of auditors. It is understood that the Cleveland Hospital Council is endeavoring to secure a uniform system of accounting for all hospitals in the Council.

3. STATEMENT OF EARNINGS—The monthly and annual statements of earnings of hospitals should be based on cash receipts only. Unpaid personal accounts of hospitals have no place in a statement of earnings. The present earnings and income reported to the Cleveland Hospital Council and Welfare Federation from the various hospitals are not comparable for the reason that some hospitals base their statements on cash receipts only, while others include unpaid personal accounts in their statement of earnings. (Note A.)

Note A—The practice of many hospitals in carrying unpaid personal accounts on their balance sheet as an asset is misleading, fallacious and wrong in principle. A varying percentage of most of these accounts are uncollectible because they are largely accounts of part-pay patients. If the statement of earnings includes cash receipts only, such open accounts as are paid after the patient leaves the hospital will appear in the statement of the month during which they are paid. It is impossible to estimate the percentage of unpaid hospital accounts that are uncollectible. The good accounts are usually paid within a few days, while the great majority of the remainder are uncollectible.

4. APPRAISAL OF PROPERTY—An appraisal of the physical property, buildings and equipment, should be made of all Cleveland hospitals on a basis of present values. The reproduction cost of hospital buildings at the present time is in some instances at least 100 per cent. higher than five years ago. A proper percentage for annual depreciation cannot be established without an appraisal. It is also necessary in order to determine valuation for fire insurance, etc. It is possible that the expense of an appraisal could be lessened if the Cleveland Hospital Council made a contract for all the hospitals represented in the Council. The expense could then be prorated between the hospitals according to property values.

5. DEPRECIATION—Depreciation of buildings and equipment should be charged off annually. The bookkeeping system recommended in paragraph one should provide for an annual depreciation charge.

6. PER CAPITA COST—All expenditures for current repairs, new equipment, replacement of equipment and betterments to existing buildings

should be charged to maintenance account. The per capita per diem cost of maintenance will thereby be placed on a uniform basis for all hospitals. Expenditures for new buildings, and equipment for new buildings, should be charged to capital expenditures. (Note B.)

Note B—The per capita cost per diem for maintenance has been reported for Cleveland hospitals as follows:

(a) For 1918, minimum, $1.69; maximum, $4.60

(b) For 1919, minimum, $2.00; maximum, $5.62

(Not including Warrensville Infirmary or the City Hospital). It is believed that the minimum per capitas reported do not actually represent the true per capita cost.

7. CASH DISCOUNTS—Cash discounts should be taken on all bills where possible. Experience in hospital accounting has demonstrated that legitimate cash discounts will represent one-half of one per cent. of total expenditures of general hospitals, or two-thirds of one per cent. of total expenditures for maintenance, exclusive of salaries. (Note C.)

Note C—The practice of holding bills for approval of committees of the Board of Trustees or Managers is pernicious and accounts for failure to obtain some cash discounts. The Board of Trustees should put in the hands of hospital superintendents full authority for approving bills for payment of all current expenses. Extraordinary expenditures could be authorized by the Boards of Trustees before order is placed by superintendents. Hospitals which habitually pay bills after 30, 60 or 90 days cannot purchase to good advantage in the open market, and have a poor credit rating. It may be necessary for the Cleveland Hospital Council to establish a fund to cover the discounting of bills for smaller hospitals.

8. RATE FOR WARDS AND ROOMS—Ward rates are ridiculously low, averaging $2.00 per day. These rates should be raised to at least $3.00 per day, which figure represents only part cost of maintenance. Private room rates in some hospitals are also low and should be advanced. Board bills for ward and room beds should be collected one week in advance for general cases, and two weeks in advance for maternity cases. Therefore, patient's relatives should be billed weekly in advance. Recognition should be given the fact that wages and salaries are materially higher than when these rates were originally established. It should be understood that ward and room rates cover bed, board, pupil nursing, interne service in the larger hospitals, certain routine and diagnostic services, and for free and some part-pay patients, gratuitous medical attendance.

9. RATES—COMPENSATION—The rate formerly allowed by the Ohio State Industrial Commission for compensation cases was outrageously low. Such rates should be established on a basis of cost of maintenance. $3.00 to $3.50 per day, plus charges for all extras, will represent the approximate cost of

ward patients, at present. The Cleveland Hospital Council has taken the commendable stand that hospital cost for hospital service should form the basis for the establishing of hospital rates by the State Industrial Commission, and it is gratifying that the Council has recently secured recognition of this principle from the Commission.

10. RATES FOR MUNICIPAL AND COUNTY PATIENTS—The charge for the care of these patients should be based on the average cost of maintenance for the preceding year and be a matter of annual adjustment. It should be based on per capita per diem cost. No hospital should accept a lump sum or subsidy from any municipality, state or county authorities. Contract should never be made for the care of the sick on the basis of a lump sum annually.

11. EXTRA CHARGE SCHEDULE—A charge schedule for extras should be adopted by all hospitals, and charges made for many supplies and much service that is now rendered free. Few Cleveland hospitals have an adequate extra charge schedule. Hospital clients think nothing of paying for all services rendered at a hotel or elsewhere. Extra charges for supplies or services for part-pay patients can be cancelled or reduced at discretion where patients are unable to pay. The following schedule of charges is suggested:

Blood transfusion for private patients	$50.00
Blood transfusion for ward patients	25.00
Large surgical dressings	1.00 to $2.00 each
X-Ray and stereoscopic examinations	10.00 to $40.00
Board of Special Nurses	1.50 per day and up
Plaster casts	2.00 to $10.00
Services of hired anesthetist	5.00
Nitrous oxide gas and oxygen	5.00 per adm. hour
Salvarsan administration	5.00 to $10.00
Proprietary drugs, patent medicines, serums, ampules and special prescriptions	Cost plus 10%
Splints and surgical appliances	Cost plus 10%
Meals for relatives of patients	.75 to $1.00 each
Cots	1.00 each
Ambulance service	Cost
First-aid services for out-cases, including dressings	5.00 to $10.00
Operating-room fee	10.00
Labor-room fee	5.00 to $10.00
Special nursing	Cost
Laboratory fees for Wassermann, blood, stomach, fecal, spinal fluid examination, etc., for private-room patients.	

12. CREDIT INVESTIGATOR—(*a*) Large hospitals should maintain an investigator or credit man whose duty it shall be to investigate the financial circumstances of patients. Many patients are maintained without cost who are able to pay part cost; many ward patients are cared for at part cost who are able to pay full cost. Ability or disability of ward patients to pay for extras outlined in the preceding paragraph can be established by this investigator. The data accumulated by the Social Service department of large hospitals should be available for the use of the office investigator. It is not considered suitable for the social service worker or department to be used as financial or credit investigator to protect the business credit of the hospital.

(*b*) It is recommended that the Cleveland Hospital Council engage a credit investigator to investigate the economic status of undetermined cases in several small hospitals. The salary and expense of this investigator can be prorated over several hospitals. It is believed that the financial benefit derived from the employment of such a man would be productive of a definite increase in income to the hospitals. An alternative would be the working out of some arrangement with the local credit association.

13. CLASSIFIED WAGE AND TIME SCHEDULE—The project of the Cleveland Hospital Council, through a committee of Council members, to standardize hospital wages and hours of duty covering certain groups of hospital employes is commendable and should be carried out. It is probable that some variation in scale will be necessary in order to provide for the difference in responsibility, etc., in certain positions in large and small hospitals. Experience has shown that wages in hospitals may be standardized in the following departments:

Training School Department—Floor supervisors, ward orderlies, ward maids.

Housekeeping Department—Waitresses, chamber-maids, pantry girls, cleaners (by the month), housemen and porters.

Laundry Department—Laundresses, washmen and wringermen.

Repair Department—Carpenters, painters, steamfitters and their helpers, wall washers, window cleaners.

Engineering Department—Engineers and firemen.

Ambulance Department—Chauffeurs.

It would not be advisable to extend this classification as to wages and hours into offices, laboratories or professional departments which depend on specialists or certain skilled employes.

Owing to the difference in the size of kitchens and variety of personnel employed therein, it is not considered feasible to classify kitchen employes.

14. DISCOUNTS IN ROOM RATES TO PRIVILEGED PERSONS—The majority of hospitals in Cleveland give special rates to members of the staff and their families, to graduate nurses of the hospital and the clergy.

Hospitals with endowments primarily given for the benefit of people of lower economic status, should limit their room rate discounts to persons who give gratuitous service to the hospital. Such discount rate should not be less than the per capita cost of maintenance.

PURCHASING DEPARTMENT

1. CENTRAL PURCHASE BUREAU—The majority of Cleveland Hospitals can utilize the services of the Central Purchase Bureau to greater advantage. Several hospitals especially have neglected their duty and opportunities in taking advantage of the Central Purchasing policy. The Board of Trustees of every Cleveland hospital should satisfy themselves that the hospital under their control takes advantage of this principle to a maximum degree. Their investigation of the subject should include a comparison of prices paid by the Bureau during the last year for like commodities purchased by the superintendent of the hospital during the same period.

Full advantage of a central purchasing bureau will not be manifested until the hospitals standardize supplies.

The replies to questions referring to the efficacy of the purchasing department of the Cleveland Hospital Council, from the standpoint of the hospitals, reveal two chief criticisms:

(a) That delays in the delivery of supplies purchased through the Bureau are frequent.

(b) That prices obtained by the Bureau are in some instances no better than quotations made the hospital direct.

In reference to (*a*): it may be stated that many delays have occurred during the past year on account of slow freight, insufficient production and causes beyond the control of the Bureau. It is often necessary, in order to obtain the best prices, to purchase supplies out of town that ordinarily would be purchased by the hospital in the city. It is believed that criticisms could be lessened if the hospitals would anticipate their wants further in advance. To meet this criticism, the Bureau should make prompt delivery a requisite for the acceptance of orders, and aim to consider prompt delivery in conjunction with minimum prices.

In reference to (*b*): it may be stated that the benefits of Bureau purchasing can be increased through larger orders. The nature of many commodities does not enable the central purchasing bureau to obtain a price any lower than might be obtained by the hospital. This fact of itself should not prevent placing orders through the Bureau for most commodities, inasmuch as

the Bureau's chief advantage lies in the placing of large orders. The Bureau should keep hospitals informed of pending advance in prices.

The Cleveland Hospital Council Purchasing Bureau should systematize its Quotation Department so as to furnish without delay quotations that the hospital executive may use in comparison with prices he may have received. To obviate the lost time element, the following should pertain:

(a) Prompt furnishing of quotations.

(b) Prompt placing of orders.

(c) Prompt delivery of goods.

2. WAREHOUSING BY THE BUREAU—It is not believed that the full benefits of Central Bureau purchasing will be manifest until the Cleveland Hospital Council provides warehousing and storage facilities. Investigation shows that many of the smaller hospitals are buying in small quantities, or from hand to mouth, for two reasons:

(a) Lack of capital requisite for carrying goods in stock.

(b) Lack of storage facilities.

In view of the cooperative relationship of the hospitals to the Cleveland Hospital Council and the Welfare Federation, the remedy does not wholly lie within the hospitals. Additional storage space cannot be provided in many hospital buildings without definite building additions. Limited earning power of small hospitals precludes the establishment of a fund sufficiently large to carry a stock of goods.

Investigation and study of the cooperative purchasing bureau maintained under the auspices of the Cincinnati Community Union has thrown new light on this subject. The Cincinnati Community Union has set aside a revolving fund of $50,000 to provide for the expenses, warehousing and stock for the charitable organizations, institutions and hospitals of the city. Although in operation only a few months, the participants in this cooperative bureau are enthusiastic over the results. It is recommended that the Cleveland Hospital Council investigate the possibilities of warehousing to a limited extent in order to encourage greater use of the purchasing possibilities of the bureau. It is believed that if the hospitals of Cleveland can be assured of immediate delivery from warehouses of many staple supplies, their bureau requisitions would be greatly increased. The Cincinnati experiment has shown that the capital tied up in stock at certain times has only represented a fraction of the amount set aside. In fact, it is believed that during certain seasons of the year a part of the money set aside for warehousing stock could be drawing interest or be used for other purposes. In this connection, attention may be called to the fact that provided with warehouse capacity, the Purchasing Bureau of the Cleveland Hospital Council could take advantage of opportunities for seasonable purchases that would be neglected or considered impracticable for hospital executives.

3. AUTHORIZATION OF PURCHASES—The purchase of supplies or requisition on Central Purchasing Bureau should be made only with the approval of the superintendent, authorized purchasing agent or steward, the latter of whom should be subordinate to the superintendent. (Note D.)

Note D—The practice of direct purchases or Bureau requisitions by heads of departments or dietitians without the authority of the superintendent is pernicious and not good business procedure. The superintendents of certain hospitals first become familiar with some purchases when bills are received. Marketing in open markets by dietitians and heads of departments is good practice when properly authorized and checked by the hospital superintendent.

4. STANDARDIZATION OF SUPPLIES—The project of the Cleveland Hospital Council to standardize the majority of hospital supplies is absolutely necessary to the proper development and functioning of the Central Purchasing Bureau. Superintendents of hospitals who have preconceived ideas as to standards should come to an agreement with the committee on standardization in order that they may participate in the benefits to be derived from the uniformity of specifications, once standardization is accomplished. It will not be possible to extend the principles of standardization over all hospital supplies, but it is believed that the same can be extended over most provisions, housekeeping supplies and to a certain extent over furnishings. It is also recommended that an attempt be made to extend it over certain staple drugs and surgical supplies.

5. STORAGE FACILITIES AND ADVANCE PURCHASES—Hospitals should aim to take advantage of minimum prices that may be obtained through

(a) Quantity purchases.

(b) Purchases in advance of needs.

This plan necessitates increased storage or warehouse capacity for some hospitals.

Advantage can be taken of the markets by the seasonable storage of the following goods: canned goods, coffee, tea, navy beans, sugar, soap, starch, laundry soda, flour, butter, eggs, dried fruits; and sometimes crockery, glycerin, lard, narcotics, certain bulk chemicals, manufactured dry goods, etc.

Sufficient eggs should be stored in public warehouses in April, and butter in June, for hospital consumption during the months of maximum high prices. (October, November, December and January.)

Egg candling and storage should be carried out only by reputable and high class firms who will guarantee quality at time of consumption. Eggs should never be stored in anything but new cartons.

6. INVENTORIES—Physical inventories should be taken on the last day of each month, comprising all material stock in storerooms. The practice of most hospitals of depending on book inventories is fallacious and not justified in commercial practice, except for the drug department. (Note E.)

Note E—This recommendation comprehends inventory of unissued stock supplies such as groceries and provisions, household supplies, gauze and cotton, dry goods, laundry supplies, in storeroom awaiting issue. Warehouse supplies should, of course, be included. Once the system of monthly inventories is established on standard inventory blanks, one office employe assisting the steward or proper head of department, can take inventory and complete records in one or two days, depending on the size of the hospital and the amount of goods carried in stock. It is estimated that the hospital which does not carry on inventory a stock of supplies equal to 10 to 15 per cent. of its annual purchases, is not taking advantage of seasonable purchases or storage possibilities. In this connection, attention is called to the fact that certain suppplies, soaps for example, improve in storage, and that but few supplies deteriorate.

7. CONTRACTS—Annual, limited or quantity contracts should be sought for certain supplies; notably coal, electric lamps and milk from producers. It is strongly recommended that all hospitals make arrangements to obtain their milk supply from the producer rather than depend on commercial distributors.

8. DRUGS AND SURGICAL SUPPLIES—It is recommended that the Cleveland Hospital Council employ or develop a trained drug and surgical supply man as buyer. Expert knowledge of drugs and drug markets, and a practical knowledge of the hospital use of surgical supplies are qualifications necessary. It is believed that such a man could develop the purchasing in this department and prove a decided economy after the department is organized.

The offer of the School of Pharmacy of the Western Reserve University to cooperate with the hospitals of Cleveland in the standardization and manufacture of certain drug supplies is highly commendable. The hospitals of Cleveland have an opportunity to avail themselves of the use of a drug manufacturing laboratory and expert supervision of their local drug departments that is not vouchsafed to many hospitals in other cities. It is understood that the Cleveland Hospital Council has already taken steps to take advantage of this splendid proposition.

The venereal clinics of the city should take advantage of the free provision of arsphenamine by the state.

9. FOOD SERVICE AND DIRECTING PERSONNEL—The entire food service of the hospital should be under the direction of a trained dietitian. In small hospitals it is possible to combine the service of dietitian and housekeeper. In this connection, it should be remembered that trained dietitians may make good housekeepers after reasonable experience, but that housekeepers do not ordinarily make good dietitians without special training. The service in employes' and nurses' dining rooms should be under the direction of the dietitian as well as the food service to patients. In large hospitals it is necessary to study carefully and provide for the cooperative relationship of the steward's department, main kitchens, which are usually in charge of a

chef, and the dietitian. The details of the hospital food service are too intricate to be covered by a survey of this character.

10. STEWARDS OR PURCHASING AGENTS—In large hospitals stewards or purchasing agents are necessary in order to relieve the superintendent of many of the petty details of purchasing supplies. Where a steward or purchasing agent is employed he should have assigned to him duties and responsibilities similar to those of stewards of large hotels.

HOSPITAL ECONOMICS AND SALVAGING

1. REPAIR DEPARTMENT—Hospitals of over 50 beds can economically support a general repair man for steam fitting, electrical repair and carpenter work. The painter, or painters, should be employed by the month. The repair department can be extended in personnel and equipment as the bed capacity increases. The development of a central surgical instrument repair shop for the use of all hospitals is desirable. These shops should be under the control of one or more of the larger hospitals or of the Cleveland Hospital Council. Experience has demonstrated that surgical instrument and appliance shops can be made self-sustaining almost from the beginning. Prompt, uniform and satisfactory production at a lessened cost will be the inevitable result. Such an activity might well be included among the functions of the central brace shop as proposed for the orthopedic center. (See pages 200–201.)

2. MANUFACTURING—Manufacturing of certain hospital supplies can be extended by individual hospitals in accordance with their needs and the ingenuity of the hospital executives. A central sewing room for manufacturing dry goods should have a place in every hospital.

It is only necessary here to call attention to the fact that manufacturing can be extended without limit in hospitals that have the requisite repair personnel. Some hospitals manufacture fracture beds, bed elevators, wooden stools, mattresses, cotton waste from recleaned gauze, stretcher canvass, Bradford frames, extension apparatus, splints, etc., without limit. The manufacturing of dry goods adaptable to hospital use is limitless, depending on the facilities provided. The economical manufacture of soap from grease is strongly urged, and can be carried out in the laundry with very simple equipment. Soap thus manufactured should be used for household cleaning purposes as soft soap. Laundry soap should be manufactured from soap chips.

3. WASTE AND SALVAGING—Lack of attention to waste in hospitals is uniform all over the country. It is not within the province of this Survey to discuss it. Attention is called to the opportunity for salvaging and sale of waste paper, old barrels, waste rubber, old metal, rags, bottles, etc. Surgical gauze and bandages should be washed and re-washed until worn out. It can then be reduced to cotton waste or sold with rags.

4. LABOR SAVING DEVICES—Labor saving devices should be utilized wherever possible. Electric dish-washing machines are an economy of time

and labor in any hospital. In hospitals of sufficient size, the same may be said of electric dough-mizers, meat-cutters and vacuum cleaners.

5. FIRE PROTECTION—This subject should be studied carefully by hospital trustees and executives with the assistance of expert advice. Few hospitals have a sufficient number of fire extinguishers, and where these are provided, they are not refilled with proper frequency. Only extinguishers approved by the Underwriters' Association should be used and these should be refilled twice annually. At each refilling, they should be labelled or tagged with date of refilling.

Standpipe with hose connections, fire escapes, fire buckets in attic, should receive attention. Heads of departments should be drilled or instructed in their duties in the event of a fire. Fire drills are desirable, but almost impossible on account of the frequent changing of employes.

6. INSURANCE (FIRE)—It has been ascertained that many of the hospitals surveyed are inadequately insured against fire. After appraisal of buildings, old policies should be cancelled and new policies taken out on the basis of reappraisal. It is believed that fire insurance rates are due to advance and it is recommended that appraisals be made, old policies cancelled and new policies issued so as to take advantage of present rates. It is preferable that hospital insurance policies be drawn for five-year periods, which provide for lower rates. Co-insurance policies are not recommended except for fire-proof buildings. For non-fire-proof buildings a maximum coverage is recommended by means of straight policies. The contents of hospital buildings should be fully insured as most hospital fires are small and the contents suffer to a greater degree than the buildings. Owing to the recent rapid increase in construction cost, hospitals should examine their fire insurance policies without delay and increase them to a figure approximating present values.

Compensation insurance covering employes should be carried by all hospitals. Elevators and automobiles should also be properly covered.

GENERAL RECOMMENDATIONS

PROFESSIONAL

1. It is recommended that standing house orders be established:

(a) For preparation of patients for operation.

(b) For after-care of surgical cases.

(c) For preparation of patients for confinement and after-care (pre-natal orders); (post-natal orders).

(d) For preparation of patients for operation and after-care in tonsillectomy.

2. That large hospitals sterilize and manufacture prepared catgut from raw catgut.

3. That large hospitals manufacture nitrous oxide gas.

4. That arrangements be made to purchase oxygen of local manufacturers rather than of jobbers. This will necessitate the hospital owning its own tanks which can be sent to manufacturers for refilling. All large cities have a number of plants manufacturing oxygen as a by-product. Its cost under these circumstances should be 50 per cent. less than prices paid jobbers.

5. That rubber gloves be not issued at the expense of the hospital to staff members for use on private cases, or to non-staff physicians.

VISITORS AND VISITING HOURS

Visiting the sick should be limited as much as possible, especially in open wards. Hospitals where possible, should reduce visiting days to three or four days per week, including Sundays. Two of these days could have visiting hours for wards 6:00 to 7:00 or 7:00 to 8:00 P. M., and the remaining two days 2:00 to 3:00 or 3:00 to 4:00 P. M.

Visitors to private rooms are difficult of regulation. They should be limited if possible to afternoons between 2:00 and 5:00 P. M.

Non-professional visitors in the operating room during operations should not be permitted. The practice of allowing relatives of patients to witness operations is dangerous and susceptible of much criticism. It should not be permitted.

HYGIENE OF HOSPITAL AND PERSONNEL

1. HEALTH TESTS—All employes handling or preparing food either in storerooms, kitchens, pantries, dining rooms, diet kitchens, etc., should have a complete physical examination, including a Wassermann examination, before being accepted for appointment. The medical examination and tests made should be adequate to exclude typhoid carriers from this service.

All nurses before admission to the training school, and employes before assuming duties of their positions should give evidence of a recent vaccination against smallpox, or be vaccinated.

In the event of development of cases of diphtheria among hospital personnel, all employes and nurses should have the Schick Test to determine susceptibility. The making of a Schick Test as a routine procedure prior to employment or entry to the training school, is unnecessary. It should not be neglected, however, in the face of an epidemic.

The authorities of the hospital should provide for and encourage medical exmination of all their employes annually.

2. MILK SUPPLY—Hospital laboratories should install apparatus for testing their milk supply on delivery daily. Determination of quantity of butter fat, bacteria content, temperature and specific gravity will permit

checking of contract which would provide for certain minimum standards. Hospital milk should be cooled to 50 degrees immediately after milking, delivered at the hospital before reaching 60 degrees and contain not less than 4 per cent. of butter fat. The milk contract should call for milk for drinking purposes known as Class "A" grade. Milk should be delivered to hospital raw and provision made at hospital for pasteurization for such milk as may be desired pasteurized prior to use. (Note G.)

Note F—Class "A" milk in Cleveland is raw milk from tuberculin-tested herds, scoring 90 per cent. or better, with less than 50,000 bacteria content per c.c. It may be necessary in some instances to use Class "B" pasteurized milk, which conforms with Division of Health standards.

3. WATER SUPPLY—The hospital laboratory should periodically test the water supply. If storage tanks are in use, tests and culture should be made from tanks as well as spigots.

4. VENTILATION—During the winter months, hospitals with the plenum system should give rigid attention to the details of this system with frequent examination of air in wards and exposure of culture media. Hospitals using direct-indirect methods combined with heating, during winter, should make weekly examinations of air as a check on the mechanical operation of exhaust fans and the mechanics of the ventilating system.

III. Dispensaries

DISPENSARIES IN CLEVELAND

As outlined in the section entitled "Some Definitions," and as shown in Figure III., Part II., there are two classes of dispensaries in Cleveland—those treating the sick and those primarily concerned with preventive work, or the clinical and the public health dispensary, as the two types may be called. In Cleveland, five dispensaries treating the sick deal with general diseases; one, the Babies' Dispensary, confines its work to children under three years. There are also a number of industrial dispensaries supported by business establishments for the treatment of accident cases. The industrial dispensaries are dealt with in Part VII. of the Survey report, and are merely mentioned here. The public health dispensaries are dealt with in the next section of this chapter.

All of the dispensaries treating the sick except the Babies' Dispensary and the industrial clinics are attached to hospitals, and are usually called the out-patient departments of those hospitals. All of the public health dispensaries, on the other hand, are distinct from hospitals, with the exception of a few of the prenatal clinics.

The six dispensaries treating the sick are as follows:

Dispensaries	Dispensary Visits, 1919
Lakeside Hospital—Out-patient Department	59,891
St. Vincent's Charity Hospital—Out-patient Department	21,863
Mount Sinai Hospital—Out-patient Department	19,324
Babies' Dispensary and Hospital	14,977
St. Luke's Hospital—Out-patient Department	13,313
Huron Road Hospital—Out-patient Department	5,864

It is probable that the number of different individuals treated was about 30,000 in 1919.

From the above table it will be found that the dispensaries of Cleveland are comparatively few in number and small in size as compared with those of other leading cities. In the section on "Policies and Needs," such comparisons will be made. In this section the general work of the dispensaries is reviewed.

LOCATION OF DISPENSARIES

The six out-patient dispensaries are very unevenly distributed—Lakeside is on the lake at East Twelfth Street; Charity is one mile inland at Twenty-second Street; and Mount Sinai about one mile and a half inland at 105th Street. These three dispensaries treat all kinds of diseases. Huron Road Dispensary, located in the center of the city, does very little except surgical

Fig. III.

NOTE:—The height of the black rectangles represents the percentage of dispensary patients living in the district and attending the dispensary designated by the letter above.

emergency work; the same is true of St. Luke's, which is in the middle of an industrial district. The Babies' Dispensary, not far from Charity Hospital, confines itself to sick babies up to the age of three years.*

A study of locations shows that the dispensaries are not so located as to interfere with one another, but it is obvious that the west and south sides of the city are entirely without provision. The range from which patients come to the dispensaries varies considerably as shown by Fig. III. In Cleveland, as elsewhere, it is found that a dispensary with medical teaching draws from a relatively wider area, since consultation cases are sent to its staff for special study and since the reputation of its staff draws patients. In general the range of a dispensary varies somewhat in proportion to its reputation. People will go long distances to secure expert medical care of which they feel themselves to be greatly in need, but convenience of location and nearness of a dispensary are of great assistance in bringing people in the early stages of disease under care and in attaining easy supervision of treatment.

CLASSES OF DISEASE TREATED

Tuberculosis is not cared for in these dispensaries except in so far as diagnoses are made when patients come into the dispensary with other complaints, but the supervision and control of cases of tuberculosis are carried on by the Health Centers and the special sanatoria for this disease. The common "contagious" diseases are also excluded from dispensaries.

ORGANIZATION AND EXECUTIVE CONTROL

The management of a dispensary of any size, such as those at Lakeside and Mount Sinai, involves the handling of a considerable number of patients and a number of physicians, nurses, social workers, and other assistants, and needs skilled and executive direction. Rarely, however, has there been provided by the hospital any officer responsibly charged with full control of the dispensary and expected to give to it his main attention. At Lakeside and Mount Sinai, an assistant superintendent of the hospital is director of the dispensary, but at Lakeside until recently the actual conduct of the dispensary fell entirely upon the head of the social service department. At the smaller dispensaries—at Huron Road Hospital and at St. Luke's Hospital, and also at Charity Hospital, there have been no executive directors. The hospital superintendent is responsible for the dispensary as well as for other departments of the hospital, but no official has been assigned to take charge of the dispensary.

Only at the Babies' Dispensary has there been definite and continued executive direction and carefully worked out organization, under the professor of pediatrics at the University, with a salaried nurse devoting her full time to the detailed administration. This organization has indeed devoted too much attention to its own executive detail and administrative system,

*A small number of orthopedic cases receiving special treatment are accepted up to 14 years of age at the Babies' Dispensary.

but furnishes on the whole an example of the value of a well-thought-out and well-worked-out plan of dispensary administration under full-time, responsible executive direction.

BUILDINGS

The Babies' Dispensary is especially well designed for its purpose. The other dispensaries are all hampered for want of room or from old dark buildings. St. Luke's and Charity function in basements; Huron Road in a rather forlorn annex; Mount Sinai in a small double house; and Lakeside in poorly-arranged, inconvenient rooms. All of the institutions except Charity are planning new buildings, and Lakeside is planning certain modifications of the present plant that will make it much more suitable during the remainder of the time the building is in use. The unsuitable or inconvenient character of the plants is typical of the lack of attention paid to dispensary work in the past, while the increasing interest in this form of service is reflected in the projected developments.

PATIENTS

As shown on the map (Fig. III.), the existing dispensaries draw their patients largely from the central congested areas of the city. Sufficient numbers come from a distance to show that when the work and existing value of dispensaries is known, distance is not an insuperable obstacle. It would be interesting and important to ascertain how far the distribution of dispensary patients by districts agrees with the economic condition of the population in each section. Obviously, the dispensary draws primarily from the poorer elements. There are considerable districts in the west and south sides which appear to contain a large number of people who are financially as much in need of medical charity as those who are near the existing dispensaries. Some light is thrown on this point by the study of nationalities. Thirty-three nationalities were found registered among records studied in the six dispensaries. The proportion of foreign-born found in the more recent of these records of races is smaller than the proportion which these races bear to the total population of Cleveland. Knowledge of dispensaries and willingness to go to a strange institution penetrate only slowly among many groups of immigrants. At Lakeside Dispensary, American-born patients constituted over one-half of the total; Charity draws largely from Italians and Negroes; Mount Sinai shows over half of its attendance, Jewish; Babies' Dispensary shows 24 per cent. American-born parents, 18 per cent. Slavic, 16 per cent. Jewish, 14 per cent. colored, and many other nationalities represented in small percentages. Very little has been done at any of the dispensaries to provide interpretation for patients not speaking English. There is much complaint from outside charitable agencies that adult patients not speaking English find it difficult to make themselves understood, or to understand what the doctor finds to be the matter or what he wants them to do.

FEES AND FINANCES

It is becoming the general policy of dispensaries throughout the country to charge admission fees at each visit of a patient, the fee usually being of nominal amount (except in "pay clinics") and being remitted in whole or in part where the patient is not able to pay. In Cleveland, only one of the five general dispensaries, Lakeside, has adopted a general admission fee in its daytime clinics. Mount Sinai Dispensary charges ten cents for the first admission but not thereafter, and Charity makes a nominal charge when a person loses his admission card. All make charges for medicines at prices more or less corresponding to cost, and also usually charge for special treatment or appliances.

In the evening clinics which are designed for persons who are at work in the daytime and generally aim to be quite or nearly self-supporting, fifty cents a visit is charged by Mount Sinai, Charity, and Lakeside—the three dispensaries which maintain such clinics. Babies' Dispensary has a grade system—the highest class pays fifty cents and the lowest grade nothing for admission.

The charging and collection of fees and the designation of what these fees should be and when and why they should be remitted, require an adequate admission system for a dispensary. The present inadequate organization of most of the institutions would make it difficult to administer satisfactorily an admission fee system. It is of course essential that if admission fees are routinely charged, there be a system for receiving and accounting accurately for monies, as well as for deciding what fees should be paid by patients or be remitted. Having such a system in a dispensary is always stimulating to better administration and also serves to provide the funds for it. An important by-product, moreover, is the greater attention given to the economic and social condition of patients, promoting more careful attention to the social as well as the medical needs of those admitted, and protecting the medical profession better against those who could properly pay for the services of a private physician.

The exact cost of dispensary service in Cleveland is not ascertainable because no one of the out-patient departments of the hospitals fully separates its expenses from those of the hospital. Immediate expenses are usually charged to the dispensary, but the overhead—heating, lighting, supervision, and other general expenses—are not usually figured in. It is probable that the average cost per visit does not exceed fifty cents with the exception of the Babies' Dispensary, which is independent of a hospital. The five out-patient departments of the hospitals, with about 115,000 visits, probably cost altogether about $60,000 a year. Really adequate administration of the dispensaries as hereafter recommended would cost more, but the difference would be met or more than met if adequate admission fees were charged. Failure to have proper cost accounting is a serious limitation on dispensary service. What seems cheap, is held cheaply.

MEDICAL WORK OF DISPENSARIES

Physicians work in the daytime clinics of the dispensaries without financial remuneration, except in a few instances of physicians doing special work at Lakeside and at the Babies' Dispensary. These two dispensaries are teaching clinics for Western Reserve University, members of the staff being also members of the staff of the medical school. In the evening pay clinics, all the physicians receive either a regular salary or an amount dependent on the fees received from patients. A large part of the dispensary work in Cleveland is connected with the teaching of medical students, all of the staff at Lakeside and at Babies' Dispensary, and part of the staff of Charity and of Huron Road, being connected with Western Reserve University Medical School.

The dispensary staffs are only in a few instances organized satisfactorily in relation to the staffs of the hospital with which the dispensary is connected. (See section on "Organization for Service.") The practice of making all appointments annually has been taken advantage of only at Mount Sinai. The Babies' Dispensary is the only one that has an accurate and complete enough system of record keeping to afford a basis for clinical research. Most of the opportunity for the student is lost because of inadequate records, and much duplication of work among dispensaries and within the same dispensary is necessitated for the same reason.

Opportunities for consultation among physicians representing different specialties is an important element in good dispensary work, but this opportunity is relatively small in the Cleveland dispensaries owing to loose organization and to very lax systems of referring and transferring patients between dispensaries or clinics. The making of efficiency tests of the medical work and the accumulation of facts on which to base judgment concerning administrative procedures has yet to be undertaken.

RECORDS

All of the five general dispensaries excepting Charity have a central filing system—all records concerning each patient being filed together. At Charity, the filing of the records of each particular clinic separately represents a serious drawback since the work of the different specialists upon a case cannot readily be assembled and the needs of the patient studied as a whole. Card record forms for the medical work are in general use, differing widely in detail. Conference and comparison would lead to improvement and standardization. Mount Sinai has a plan for a summary sheet for diagnosis and laboratory tests, an experiment which is worth pursuing.

SOCIAL SERVICE

The too considerable part played by under-staffed social service departments in the administration of several of the dispensaries is described in detail in the section on "Social Service". It may be mentioned here that in relation to cooperation with charitable agencies, the social service de-

partments have usually made an effort to define their attitude toward the social agencies, particularly in relation to the need of patients for material relief. All of the social service departments are avowedly opposed to the giving of material relief, regarding this as the duty of a "family agency" or relief society. In general an exception is made of certain medical needs which the social service departments regard as adequate reason for giving financial aid. Thus at Mount Sinai, it is felt that a patient's inability to pay for glasses or for dental work is an indication that there are other more general financial needs and the case is transferred, by the social service department, to general charitable or relief agency. Lakeside Social Service Department will give money to patients for carfare and occasionally will make small loans. A very small fund is in the possession of this department for such purposes. The Babies' Dispensary provides milk at less than cost or free, if necessary. This is provided for babies up to the age of fifteen months; after that if the baby is ill, it will be continued up to eighteen months, but never later. This is also done at the Health Centers. The total deficit for the year 1919 was $18,000, of which the city pays $6,000 and the Babies' Dispensary $12,000. With these exceptions the social service departments do not give material relief, but transfer to charitable agencies all cases in which such needs appear evident or probable. Thus a pretty clear division of function between the social service department and the non-medical agencies has been worked out.

On the other hand, there has not been a satisfactory understanding between the dispensaries and the charitable agencies with reference to the examination of patients not acutely ill, but concerning whom a charitable society needs to secure facts as to physical condition, working ability, and the general health needs of the family. In some instances, notably at Lakeside, it has been difficult for charitable societies to secure examination of these cases, who often not being sick, do not interest physicians coming to the dispensaries primarily to see and treat illness. It has also been difficult, at Lakeside almost impossible, for charitable societies and agencies, to secure information regarding the diseases or defects found in patients in whom they are interested. The families known to charitable societies and receiving relief from them, can obviously not afford to pay for medical care, and it is particularly for such families that dispensaries should serve as family physicians. This means providing health examinations and advice concerning occupation, nutrition, etc., as well as diagnosis and treatment during illness. The dispensaries have given only a very limited degree of service in this connection, although a real beginning has been made at such places as the Babies' Dispensary and Mount Sinai. An important field for larger service lies here.

REPORTS AND TESTS OF DISPENSARY SERVICE

The annual reports of the dispensaries are most inadequate. The dispensaries probably serve altogether, in a year, as many as 30,000 persons—hospital beds, 50,000 to 60,000, or twice as many. Yet the attention devoted to reports of hospital work is not twice as much as that given to dispensary reports, but ten times as much or some such ratio. Even the number of

patients served or treatments given in each of the several clinics—medical, surgical, etc., were not obtainable from the dispensary reports, (except from one institution) and had to be specially secured for the Survey. The authorities of the institutions have not provided themselves with the elementary data with which to judge even the scope and amount of service rendered, much less its quality. The collection of routine statistics of the work of each clinic is a matter neither difficult nor costly.

DEFICIENCIES IN CERTAIN BRANCHES

Like the hospitals, the dispensaries are undeveloped in certain important specialties in which the public needs service. Clinics for children (over the age of three) are the most notable example. The children's clinics at Lakeside and Mount Sinai are very small; there are none at Charity Hospital, Huron Road, or St. Luke's. The age limit set by the Babies' Dispensary has been an unfortunate restriction. It has served to limit the development of clinics for babies elsewhere, and has indirectly tended to diminish the chance of adequate clinics for older children. Moreover, no one clinic for sick babies can meet the need for a city as large as Cleveland. All sick babies needing dispensary care are expected to come to one spot, the Babies' Dispensary, and even when there they are not treated unless the nurse at the admission desk agrees with the mother, or with the visiting nurse who referred the mother, that the baby is too ill to be at a Babies' Prophylactic Station and that the family is too poor to pay a private physician. A study by the Survey showed that somewhat more than half of a group of cases recently applying at the Babies' Dispensary were referred elsewhere. It is to be strongly recommended that: (1) Babies' Dispensary accept children up to 14 years. (2) Pediatric Clinics treating children up to this age be developed at all present and future dispensaries.

Clinic service for cases of heart disease is an undeveloped field in Cleveland. Mount Sinai appears to have recognized the problem and to have begun efforts to get cardiac cases under care, at Rainbow Hospital. It is highly desirable that cardiac clinics be developed as parts of the general dispensaries which exist or are to be established at City Hospital, Lakeside, Mount Sinai and the proposed central downtown dispensary.

RELATION OF DISPENSARIES AND HOSPITALS

The usefulness of the out-patient department as a means of increasing the efficiency of the hospital has been but slightly recognized in Cleveland. The dispensary should be the link whereby most of the hospitals' contacts with the community are made. Thus the admission of ward patients should be largely through the dispensary, though of course emergency and some other cases will enter otherwise. The medical study given in the dispensary to the patient should be the beginning of the hospital's work with him and not, as now, be usually wasted because the medical organization and the records of the out-patient department are not correlated with those of the hospital.

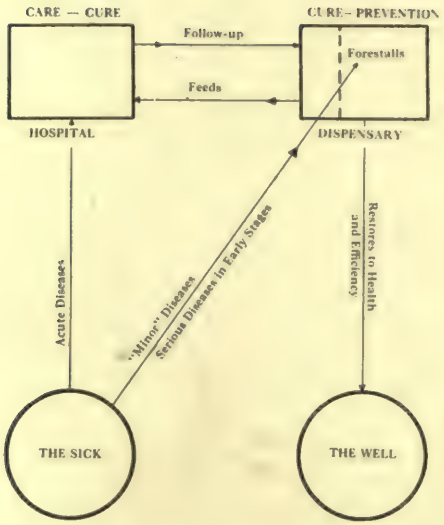

Fig. IV.

Inter-relation Between Hospital and Dispensary.

Of equal if not greater importance, is the function of the dispensary in connection with the discharged patient. This subject is studied in detail in the sections on convalescence.

CLINIC MANAGEMENT

The time of doctors, given freely to service in clinics, is much too largely spent in non-medical routine—calling in patients, attending to records, etc. Paid and trained clinical assistants is necessary if the doctor's time in the clinic is to be of maximum value to himself and to the patient. The details of efficient clinic management have been worked out in a number of dispensaries in other cities.

RELATIONS TO THE MEDICAL PROFESSION

There has been for some years an apparent feeling on the part of some members of the medical profession that dispensaries interfere with private medical practice because they accept patients who could afford to pay a physician. Much of this feeling has been due to misapprehension of the facts; some has been due to the failure on the part of the hospitals to deal with the medical profession on even and open terms. The Survey has found no evidence that cases who are able to pay a private physician have been accepted by the dispensaries except occasionally, by mistake or honest misjudgment, and the proportion of such mistakes appears no larger than studies in New York and Boston have shown to be practically inevitable. The proportion of dispensary applicants who are able to pay private rates for the medical care which they need is believed not to be larger than three per cent. and as the records of the Babies' Dispensary, of Lakeside, and of other institutions show, a number of such applicants are refused treatment. The principles which it is believed should govern the admission of patients to dispensaries are stated in the section on "Policies and Needs."

It has been unfortunate that this vital matter of relationship between the dispensary and the physician should not have been made the subject of systematic cooperation, conference and study by representatives of both sides. Had, for instance, a committee of the Hospital Council met with a committee of the Cleveland Academy of Medicine a number of times during the past five years, there would probably never have developed any attitude of disagreement. In the section on "Policies and Needs" a recommendation is made with the aim of bringing about such cooperative functioning. It is of vital importance to remember that the dispensary (also the hospital) is essentially a cooperative enterprise of the medical profession and the trustees and administrators, undertaken for the purpose of community service. The adequate development of dispensaries in Cleveland will offer to the rank and file of the medical profession opportunities of which it is now largely deprived—for consultation with specialists and for aid from laboratories and other facilities in diagnosis and treatment. Physicians may be sure that

whatever assists the public to give more attention to bodily health and to understand and utilize the most advanced resources for medical care, will also stimulate the use of that primary and best loved resource, the family physician.

THE PUBLIC HEALTH DISPENSARIES

As previously pointed out, the public health dispensaries differ from those just described in that they lay emphasis on preventive work rather than on diagnosis and treatment of sickness. They also differ in that each public health dispensary limits itself to a definite area, receiving patients only from this district. Generally speaking, the offer of a preventive and educational service will draw persons from a much smaller area than in the case of a clinic treating sickness. The effective range of an infant welfare clinic is quite small; that is, the area from which it will draw many cases is limited to a comparatively small region around the dispensary. The same is true of the prenatal clinic, while the tuberculosis clinic has a somewhat wider range. In practice the district which a public health dispensary does serve depends largely upon the extent to which it is advertised or the degree to which nurses attached to the dispensary go into homes and interest persons to come to the clinic. These efforts, however, are at a disadvantage if an attempt is made to bring many persons from considerable distances.

The public health dispensary has a militant purpose. It aims to combat a definite disease like tuberculosis or a group of diseases such as cause infant mortality. It should make no restriction in receiving patients because of financial status. Properly conducted, a public health dispensary should in no way interfere with the work of private physicians, but tends to send patients to them since disease or difficulties are discovered which dispensaries will not treat and for which patients will be advised to seek treatment. The aim of a public health dispensary is, or ought to be, the reaching of all of the cases within a certain district needing its care. It must measure its work on a population basis and see how far it is able to reach 100 per cent. of the cases of actual or probable tuberculosis in its district, or all the babies or expectant mothers. This in practice would require that a public health dispensary, with a certain staff, must serve only so large a district as it can effectively reach. The time has not yet come when a general statement can be made as to the area which a given type of public health dispensary can cover, and this must be the subject of further study in Cleveland and elsewhere.

Reference to Table I. shows that twenty-two different sites are utilized for public health dispensaries or clinics with a public health purpose, and that the purposes served include four types of work: tuberculosis, infant welfare, prenatal care, and dental service. It should be added that the three clinics treating the venereal diseases (at Lakeside, Mount Sinai and Charity Hospitals) fall on the border line between the public health dispensary and the dispensary treating the sick. They have or should have the militant purpose of the public health dispensary, but they are largely concerned with the diagnosis and treatment of definite disease. Since Part V. of the Survey report is devoted to venereal diseases only this mention is made here.

Further reference to Table I. indicates that the first two of the four services, tuberculosis and infant welfare, are under the charge of the Division

of Health, while the other two, prenatal and dental service, are under private agencies. The Survey reports on Child Hygiene (Part III.) and on Nursing (Part IX.) have given considerable attention to prenatal as well as to the other public health services which involve the nurses' work in the home as well as in the clinics, and the report on Tuberculosis (Part IV.) has covered that field. Certain administrative aspects may properly be discussed here

PRENATAL CLINICS

In prenatal service the function of the clinic is essentially diagnosis. The examining physician should, so far as possible, be able to decide what special care, if any, each expectant mother requires during pregnancy and at delivery, and to advise her accordingly. The diagnostic and administrative work of the clinic are of relatively limited value without the home work of the nurse. The prenatal clinics also play a certain part in medical and nursing education. It should be apparent, however, that the amount of clinical service or the number of obstetrical cases, needed for such purposes of education, is only a small fraction of the amount of prenatal service needed for the community as a whole. In 1919 there were 19,123 registered births in Cleveland, and of these 1,251 were delivered in their homes by out-patient teaching services connected with the prenatal clinics of Maternity Hospital. This is 6½ per cent. of the total. It is certainly true that not over 10 per cent. of the obstetrical cases of Cleveland are required, or could even be directly utilized, for teaching purposes in connection with prenatal clinics. Practically every expectant mother would benefit by such service as is rendered at a well managed prenatal clinic. The need of prenatal care is far broader than the need for "educational material." The two purposes are not at all inconsistent. The one fits into the other.

The point is of practical importance because of the failure of those responsible for the University teaching of obstetrics and for the maintenance of the prenatal clinics connected therewith, to recognize the community need as broader than their own special interest. Four different agencies maintain eight prenatal clinics. There is room for many more than eight prenatal clinics and for more than four agencies, provided all were working as part of an agreed general program. At present the University agency appears to take the attitude of urging the cessation of the activities of such prenatal clinics as those of Mount Sinai and the University District. The feeling produced on the other side is what may be expected. The effectiveness as well as the extent of the work is substantially diminished by such a situation. As a *reductio ad absurdum* we find two prenatal clinics, next door to one another, at 2509 and 2511 East Thirty-fifth Street, one conducted by Maternity Hospital, the other by the University District, for the training of its students.

The recommendations made by the Survey in the reports on Child Hygiene (Part III.) and Nursing (Part IX.) will remedy this condition if put into effect. It may be added here, as one detail, that there is no justification for two

clinics side by side on Thirty-fifth Street. Although the University District prenatal clinic is actually under the auspices of the Division of Health, it, as well as the Maternity Hospital prenatal clinic, is used as a teaching field by the University, and it is largely the responsibility of the University to see that its agents and officers dealing respectively with medical and with nursing education, work in harmony. The two clinics should be combined. It is a matter of indifference which plant is retained and which given up. The University should, as now, appoint the medical and nursing heads of the service; the internal administration of the clinic, for reasons of economy and convenience, should continue under Maternity Hospital; the nursing teaching should be part of the University District plan and be coordinated with the community plan for prenatal and obstetrical nursing service proposed by the Survey. (See Part III.)

It is generally helpful for a hospital which has a considerable maternity service in its wards, to maintain a prenatal clinic (which should be used also for the supervision of post-partum conditions and be administered as part of the general dispensary attached to the hospital). Such hospital clinics should, however, work as cooperative parts of the city-wide plan for maternity care. There is need for many more prenatal clinics, however, than are or can be connected with hospitals. Wherever possible the prenatal clinics should be in the same buildings as the Health Centers of the Division of Health. By the bringing together of a variety of different health activities within one building, each service tends to strengthen the others by increasing the contact of the neighborhood with the Center, its purposes and personnel; and to correlate many details of work by the medical, nursing and clerical staffs. Such combinations also bring administrative economies in management and save such present wastes as renting rooms for prenatal clinics which are used only a few hours each week. In advance of the assumption by the city of prenatal work as a regular service in its Health Centers, cooperation between the city and the private agencies may usefully proceed in this manner.

Dental Clinics

Dental service as a branch of public health dispensaries is a recognized activity in which Cleveland is singularly deficient.

The three mouth hygiene dispensaries operated by the Cleveland Mouth Hygiene Association at three of the health centers are operated for fifty weeks of the year, five days a week, and three hours at each session. Each unit includes a dentist and an assistant. The cost of these is met from the Community Fund as a part of the budget presented by the Welfare Federation.

These three Mouth Hygiene dispensaries, operated five half days per week, are the only available and acceptable service (except the private dental practitioner) for thirty to thirty-five thousand parochial school children. It is estimated that fifteen Mouth Hygiene Units operated eleven half days per week would serve this group of children quite well; *i. e.*, would provide the prophylactic service necessary for eighty-five or ninety per cent. of these

children and would provide for from one-third to one-half of the repair service necessary.

The grave deficiency of dental service in Cleveland is illustrated by the fact that the total clinic provision in the city includes only that at the three health centers, the six clinics at public schools and the dental clinic at the City Hospital, a total of ten dental chairs running 156 hours a week. In Boston five institutions offer either free, at or below cost, dental service with a total of 247 chairs used for 5,956 hours a week. The present policy of the College of Dentistry of Western Reserve University renders it hardly possible to class it with public service clinics for dental purposes. (See Part VIII. of Survey Report, page 685.)

Dental care for the poor in Cleveland is limited largely to extraction and remedy of gross pathological conditions causing obvious inconvenience or pain. Lack of knowledge of the needs and possibilities of oral hygiene is responsible for the neglected teeth of most dispensary patients. Dental clinics where a small fee is charged are badly needed in the congested districts.

It is strongly recommended that dental service be developed as an activity of all the health centers, including the central downtown dispensary, and that each dispensary connected with a hospital should include a dental clinic for both adults and children. The Survey has recommended to each of the major hospitals that a dental surgeon be a member of its staff, with rank as head of a department; and that under his direction a dental clinic be conducted, with the necessary dental assistance. Pay dental clinics for persons of moderate means would be a great public benefit.

THE "HEALTH CENTERS"

The tuberculosis and infant welfare work of the Division of Health may be studied from the standpoint of the management of its clinics as well as from that of the specialist in the medico-social problems of the diseases concerned. Of the eight "Health Centers," seven include tuberculosis clinics; all have infant welfare clinics, and there are in addition, six "baby prophylactic stations," subsidiary centers for the better covering of more neighborhoods.

As to buildings, three of the Health Centers are located in stores, occupying the entire ground floor in each case. Two of the stores have light from one side only; one of these two has good light from the rear. The third store stands on a lot alone and has excellent light and ventilation on all sides. All three have the advantage of unusually good front light. These three centers are the ones selected by the Mouth Hygiene Association for the installment of the dental work. Three other centers, Nos. 1, 3 and 4, are located in single dwelling houses. No. 4 has the entire house (allowing a man and wife to occupy the upper floor in exchange for the care of the store fronts); all the rooms have some daylight, making the total result better than in the stores. Health Center No. 5 is the most fortunately located of all, being

in a public bath-house, which is also a gymnasium and social club-house; there are here ample space and a fortunate arrangement of rooms. No. 8, the University District center, is in half of a double house. It is neither very light nor roomy and arrangements are poor for the work. The six auxiliary stations are: one in a library—an excellent room designed for a kindergarten room; one in a Y. W. C. A. building; one in a community center; two in public bath-houses; and one in a settlement house. One of the public schools in the downtown section is used in the summer for an extra station.

All the clinics are limited to essential equipment. They are all supplied with imported scales for weighing the babies in grams. A new dental equipment was being installed in Center 7 at the time of the visit of the Survey investigator. The buildings were not adequately heated in the cases of Nos. 7 and 3, where dependence had to be placed on stoves, with no suitable place to store coal. Nos. 1 and 4 were heated by gas stoves which markedly affected the air.

There are 35 tuberculosis clinics a week held in the seven main centers. University District does the home visiting on tuberculosis cases in its area, but gets the cases from the clinics held at Center 2. These clinics are held Monday, Wednesday, Friday and Saturday afternoons from 2 to 4 P. M., and Thursday evenings between 6:30 and 7 P. M.

In the Child Hygiene Department 46 clinics a week are held. Centers 6 and 7 each hold six clinics a week. Center 2 and the auxiliary station at Alta House hold two each a week. The other ten stations each hold clinics weekly. These clinics are held between 9:30 and 10:30 A. M. The nurses reported that Saturday was always the least crowded day.

Two other types of clinics are held in the Health Centers, but are under auspices somewhat different from those of the two above mentioned. The district doctors hold visiting hours in three of the clinics from 9 to 10 A. M. each day. An average of about six patients come to these clinics daily for dressings, or to get advice for minor ills. The number is frequently two to three and it is not infrequent for the doctor to have not a single caller.

The three dental clinics maintained by the Mouth Hygiene Association in Centers 2, 6 and 7 meet five times a week from 1 to 4 P. M., and are largely used by parochial school children and the families of patients with tuberculosis.

It can be easily seen that these clinics do not use nearly all the available daily hours. With the exception of Station 5 the rooms are idle during the other hours. Stations 6 and 7, both of which have infant clinics six mornings a week, and dental clinics every afternoon but Saturday, do not waste much time, but the other buildings could serve useful purposes at other hours. This is true of the evening hours for all stations.

The patients attending the clinics are derived from different sources. In a study made of a series of cases attending the Infant Hygiene Clinics, 57

per cent. were found to be referred by neighbors, friends or relatives; 37 per cent. referred by the Health Division and clinic nurses; 2 per cent. by the Visiting Nurse Association; and 4 per cent. by physicians. The practical value of the work is rather well illustrated by the large number of cases sent by apparently satisfied clients. In considering this, the use of the clinic in providing an inspected milk at lower than market prices must be borne in mind. It is not purely the desire for a health inspection for their children that brings the mothers.

In the tuberculosis clinics the largest percentage came in as a result of efforts of the Division of Health nurses, 46 per cent. having come in this way. 14 per cent. were referred by physicians and by friends or relatives; 11 per cent. by dispensaries and hospitals, 7 per cent. by the Board of Education (referred when there is a health problem in relation to the issue of working papers), 3 per cent. by the Associated Charities, and 1 per cent. each from the Red Cross, the Juvenile Court and the Visiting Nurse Association. The source of reference for the other cases was not stated. These figures do not refer to active or positive cases only, but to all patients that came to the clinic for purposes of examination.

There were about three times as many visits to the Infant Hygiene clinics as to the tuberculosis clinics in 1918, the last year for which the figures have been calculated. This attendance is out of proportion to the number of active cases, for there are nearly twice as many active cases of tuberculosis under care, as cases in the Infant Hygiene Clinics. This generous attendance in the Infant Hygiene Clinics is doubtless due to the insistence on the part of the clinic that the baby come in every two weeks in order that its milk be continued.

In the Infant Hygiene work the nurses give much assistance in the clinics. They weigh each baby, suggest to the mother regarding clothing and visit the cases at home to instruct in milk modification when this seems desirable. They also keep the milk book. This is a big job as well as a very large book. Each patient has to be graded as to the amount he shall pay for milk. There are five grades similar to those adopted at the Babies' Dispensary. The nurses have not established quite such hard and fast regulations as at the Babies' Dispensary, but are free to exercise some judgment. A milk that would retail at 30 cents a quart is sold at the various rates according to the family grade:

	Cost per Qt.	Cost per Pt.	Cost S. M. A.*Qt.
Rate 1	22c	15c	30c
Rate 2	17c	11c	17c
Rate 3*a*	10c	5c	10c
Rate 3*b*	5c	5c	5c
Rate 4	0	0	0

*Synthetic Milk adapted.

Any families claiming to be in grade 4 who are not referred by the Associated Charities are cleared through the Social Service Clearing House while the patient is still present. Then if the family is known to some relief agency the agency is consulted to see if the family should receive free milk. The majority of families are in rate 3a or 3b. S. M. A. costs 40 cents a quart retail. It is a special preparation of fats and oils devised by Doctor Gerstenberger and prepared in the milk laboratories of the Babies' Dispensary.

The doctors prescribe the milk for two-week periods. It is delivered by the Belle Vernon Farm Company. The child must return in two weeks or the milk will be discontinued.

Work and Personnel

The work of the Health Centers may be divided into medical and nursing work. The type of work for each group must be divided into the four departments or activities of the clinics.

Medical Work

The medical work is under the supervision of the Commissioner of Health with a department head in charge of each branch. At present the Bureau of Tuberculosis has no chief. The Commissioner of Health is therefore responsible for its activities. He is not able to give the health centers much detailed supervision. This is especially unfortunate because there are no special requirements for the doctors working in the clinics regarding experience with tuberculosis. There are eight physicians in the Bureau, each receiving a salary of $780 per year for attending five clinic sessions weekly. All the cases requiring sanatorium care or hospital admission are passed upon by the clinic doctors. The medical records would indicate that the physicians made a careful lung examination in each case. Re-examinations are seldom recorded. Sputum analysis, though not absolutely routine, is fairly frequent. Many records showed that the patients neglected to return the bottles given out for collecting sputum specimens. The doctors seemed interested in the work and there was comparatively little complaint among the nurses that the doctors were not punctual. Tonics, cathartics and cod liver oil are occasionally prescribed at the clinics.

The Chief of the Bureau of Child Hygiene takes an active part in the work. He personally conducts one clinic a week at Center 5. He visits the other centers rarely, stating that all the doctors on duty have served in the Babies' Dispensary for at least one year and do not need supervision. Much of the rest of his time is spent in the drawing of charts and collecting statistics, work which might better be undertaken in the Bureau of Vital Statistics. His salary is $3,300 a year and he devotes his full time to the work. The Chief of this Bureau is also responsible for the infant eye work and the inspection of boarding homes for children. These two functions have been so far systematized as to require practically nothing of his attention. He is also responsible for the licensing of midwives, but this is not associated with the clinic work.

The work of the physicians in this bureau is excellent in certain respects, yet lacks much that would make it of vastly greater value. The babies come to the clinic and are undressed and weighed—they are then dressed before they go to the physician. He discusses food with the mother, writes a prescription for the milk the child will need for the next two weeks and fills in its formula on a printed detailed slip. If the mother complains that the child has a cough, she is advised to take it to the Babies' Dispensary where it can receive a chest examination. The Survey investigator noted the following case. A mother brought in a two-year-old child, very thin and undernourished and unable to sleep. A private doctor had told the mother that it had worms and had prescribed medicine. At the clinic the mother was advised to return to the private doctor, although assured that the child did not have worms, and no directions were given regarding diet or general habits, which were admittedly bad. The ability to prescribe diet for infants up to 15 months is highly developed in the clinic physicians, but the giving of other health directions and the diagnosing of cases adequately enough to relieve the mother from trips to the Babies' Dispensary are not usual. The nurses complained of the difficulty in interesting the doctors in the child between 3 and 6 years. These little ones are allowed to come to the clinic for weighing and health directions, but not much information appears to be gained from the doctors which is of aid to the mothers.

The only other medical work done in the stations is the work of the district physicians who make their headquarters at the dispensaries. They are called by the nurses to visit various cases in the district, including contagious or tuberculosis cases, as occasion may require. They report to the center each evening for calls that have been left there during the day.

Administrative Work

This is all in the hands of the supervising nurses. There are two clerical assistants in each center, but the nurses complained that few of them were able to take any responsibility. The nurses do not even trust the care of the milk book and the collection and accounting of the money paid for milk in the clinics to these helpers, but nurses have to be assigned to these duties.

Social Work

There is no social work as such. All cases coming to the tuberculosis clinic are cleared through the Social Service Clearing House. All rate 3 and 4 cases coming to the child health clinics are cleared. Referring and consulting about cases depend on the interest and understanding of the nurse carrying the case. All the rating for milk is done by the nurses. The judgment used varies in wisdom, depending on the nurse doing the work. The nurses frequently attempt to make social adjustments in a distinctly amateur way.

Records and Filing

A system of filing by families has been adopted and has a certain distinct advantage. One number is given to the family and each additional member

who comes for any cause gets the same number with an additional letter. Thus there are found in the same folder cases for the tuberculosis clinic, for infant hygiene, for acute eye conditions, and possibly for a contagious condition. But keeping families in groups this way makes necessary a rather elaborate daily attendance book and careful cross indices. It is convenient when the nurse writes up the record and keeps all the records of each family together. Where general home visiting is so vital a part of the clinic work it seems an advisable plan. There is a social family history card filled out for each family at the time of the first visit; this is a form with detailed headings. There are various forms for the different departments. The infant hygiene card has a weight chart on the back and is similar in every way to the card used at the Babies' Dispensary. There are special forms on which diet is prescribed which are worthy of notice. There are forms for city hospital admission as well as admission to Warrensville. All the records seemed to be well filled out for the first visit. The routine recording of weight causes the dates of all subsequent visits to be noted, but the facts observed by the doctors were not always recorded. Each nurse keeps a daily record of her work and detailed monthly reports are filed at the Division of Health.

Financial

It has not been possible to obtain from the Division of Health an itemized expense account of the Health Centers for 1919. It is known that the expenses for the year from the three departments using the health centers was in 1919 as follows:

	Total	Salaries
Communicable Diseases	$ 53,526.97	$ 31,171.84
Tuberculosis	72,883.22	60,697.99
Infant Hygiene	65,330.05	53,352.09
	$191,740.24	$145,221.92

The rates of salaries are as follows:

Physicians

Chiefs of Bureaus	$3,300.	Full time (2)
District Physicians	3,300.	Full time (7)
Tuberculosis clinic—physicians	780.	5 clinics (8)
Infant Hygiene clinic—physicians	800.	6 clinics (6)
Infant Hygiene clinic—physicians	450.	3 clinics (9)

Nurses

Director of field nurses	$2,400	Full time (1)
Assistant director	1,980	" " (1)
Supervising nurses	1,660	" "
Field nurses—2nd year	1,440	" " (78)
" " 1st year	1,320	" "

Clerical Workers

Senior Typists	$990 or $1056 Full time (10)
Junior Typists	792 Full time (7)

. Almost 76 per cent. of the cost of the work goes to salaries. There is some income from the work, and there is another large item of expense not included in the foregoing—that is the milk, as mentioned above. The milk report for one month showed that Rate No. 1 overpaid exact cost $106. Rate No. 2, by buying of pints instead of quarts, overpaid $1.83. The other grades all underpaid, making the deficit for the month somewhat over $700. This is a small deficit; it is usually about twice that. The nurses charge $1 or 50 cents to teach milk modification at home. The dental work is charged for—Rate 1 pays 50 cents each time; Rate 2 pays 50 cents at first and 25 cents thereafter; Rate 3a pays 25 cents first and 25 cents thereafter; Rate 3b pays 25 cents at first and 15 cents thereafter; and Rate 4 gets free treatment. These dental collections go to the Mouth Hygiene Association.

CONCLUSIONS

In summary, Cleveland has made a real beginning in a public health dispensary program. Its health centers meet real needs, and their medical and nursing organization provides in the main a sound foundation both for improvement in details of service and for future advances in policy and scope. Aside from such general recommendations regarding dispensaries as appear in the next section of this chapter, the following may be made here:

1. There should be coordination between the publicly and privately supported public health clinics; notably by the utilization of publicly maintained plants (Health Centers) for prenatal clinics (see page 903). This would aid in utilizing the Health Centers to their capacity.

2. The infant hygiene work should include children up to six years. The present limitation of work to infants and children under three years of age is a great misfortune. With little additional expense better care and supervision could be extended to the children up to six. The supplying of milk, a daily necessity which makes return to the clinic vital, has swelled the attendance rather than improved the excellence of the medical work or the pertinence of the health directions. This milk plan is doubtless wise has surely resulted in preventing much illness among infants, and should be continued; but it should be a relatively smaller part of the clinic service. The doctors should develop keener and more intelligent interest in the children over 15 months, and should be prepared to write out as accurate a diet for them as for the younger children.

3. The division line between the sick and the well child should be extended a little in favor of the sick child. That is, the doctors should more freely make examinations and give at least health directions to children with colds. Skin conditions are another bone of contention, the prophylactic center doctor feeling they are "diseases" and should go to the Babies' Dis-

pensary, and the Dispensary feeling that the mild forms belong in the Health Centers.

4. The Health Centers should utilize clerical service more freely for business management and executive details, and require less of these duties from the nurses. The recommendations of the Nursing Report should be followed in this matter.

5. The Centers should as soon as possible include in their services the examination of the supposedly well, both adults and children. The offering of such periodical "health examinations" may perhaps best begin in the proposed central dispensary (see discussion of that subject), but is a proper function, ultimately, of all health centers.

6. Increase in the number of dental clinics is urgently needed as recommended in Part VIII. of the Survey Report.

7. The Health Centers should include administrative and sanitary activities, such as properly belong to a local office of a Health Division under a district form of organization. This, as well as the much-needed improvement in supervision, will be possible only with an advance in efficiency of the Division of Health, its better organization, and larger financial support.

POLICIES AND NEEDS

A comparison between the amount of dispensary service in New York, Boston and Cleveland shows a startling contrast. The 115,000 dispensary visits made during last year in Cleveland to the dispensaries treating the sick must be compared with some 3,600,000 in New York City and with some 750,000 in Greater Boston. In proportion to population, Greater Cleveland has about 14 dispensary visits per 100 population, New York about 60 per 100, and Greater Boston about 50 per 100. A further comparison may be made with Chicago, which in 1918 had 835,000 dispensary visits recorded, or about 35 per 100 of population. It will be seen that Cleveland's provision is extremely low. As brought out in the early part of this report, this deficiency is reflected in many ways in hospital service, and this will be emphasized in the following sections of this chapter; but the shortage of dispensary service also means for the community as a whole, deprivation of adequate medical care to many needy groups in the population, lack of specialist service to many more, failure to diagnose and treat many diseases during the early stages, and deprivation of consultant and diagnostic facilities to many members of the medical profession.

Preceding a statement of recommendations for improvements or increase of service to meet these deficiencies, a statement is made of certain policies regarding dispensary management and administration.

DISPENSARY POLICIES

Admission of Patients

(*a*) POLICY—In determining admission to a dispensary, the needs of the patients and the protection of the community must be the primary considerations. The medical profession has a right to be protected against imposition by persons who seek in clinics the unpaid service of physicians. when they could afford to pay for the medical care which they need. The public has a right to service.

(*b*) STANDARDS—In determining the admission of individual cases to a dispensary, three points need to be considered: namely, the income of the patient or family, the size and responsibilities of the family according to a reasonable standard of living, and the character and probable cost of adequate medical treatment for the disease or condition found. It should be added that under certain circumstances public health considerations must be the determining factor, for example, a case of infectious syphilis may demand immediate treatment, irrespective of what later disposition of the case is made. When a difficult or obscure condition must be diagnosed, or when treatment by a specialist is required, patients might be accepted whose circumstances would enable them to pay for the services of a family physician, though not for consultation with or care by specialists.

(*c*) PROCEDURE—The social service department should be responsible for the admission of new patients. Certain practical points connected with this matter will be found in the discussion of social service.

Medical Relations

(*a*) POLICY—The medical staff of the dispensary and also the organized medical profession of the community have a right to be consulted about policies or problems affecting their interests. In the case of the general profession, this should be possible through conference between representatives of the dispensary and representatives of the Academy of Medicine. The Central Dispensary Committee hereinafter proposed (page 920) would largely accomplish this purpose.

(*b*) COMPENSATION—Hospitals and dispensaries cannot expect to secure enough of prompt, regular and efficient medical service unless compensation is given to the physicians of the staff either in opportunities for study and experience, or in financial remuneration, or in both. The generous willingness of physicians to render humanitarian service is traditional and unquestioned, and should not be unduly exploited. Each dispensary or out-patient department, considering its own type of work and the medical facilities offered, must determine for itself the manner in which it can best attract and retain an adequate medical staff. The advice of central bodies such as the proposed dispensary committee and of the Cleveland Academy of Medicine would be of value in this connection from time to time.

(*c*) CONSULTATION—A definite function of the dispensary, particularly of the major institutions, is to provide consultation facilities for physicians.

(*d*) DIAGNOSTIC FACILITIES—In addition to opportunities for consultation, dispensaries should make the services of their laboratories and X-Ray departments available to the private patients of physicians (when referred by them) when such patients cannot afford the rates charged by private laboratories or by X-Ray specialists.

Fees from Patients

(*a*) POLICY—It is a good policy to charge admission fees and also treatment and medicine fees; no patient being denied a needed service because of inability to pay the stated fee in whole or in part.

The presence of medical teaching need in no way affect this policy.

(*b*) RATES—For clinics receiving the gratuitous services of physicians, an admission fee of 25 cents per visit is reasonable at the present time. It is desirable that through the proposed Central Dispensary Committee, fees be made uniform for similar classes of service.

For clinics which aim to be self-supporting and which furnish a more than nominal remuneration for the physicians, the fee should be not less than 50 cents a visit, and may be higher for certain classes of services. The basis on which such fees should be adjusted is the cost of service.

Fees for special treatments, apparatus, eye-glasses and medicines, should be fixed at or somewhat above the cost of the materials and immediate service provided.

Definite schedules of all the admission and the more usual treatment and medicine fees should be posted in suitable places in every dispensary.

(*c*) PAY CLINICS—Clinics charging fees of 50 cents or more a visit should be regarded as pay clinics and should provide financial remuneration for their medical staff. In determining the rates of such remuneration, conference with representatives of the Cleveland Academy of Medicine is suggested, or the proposed Central Dispensary Committee would serve this purpose.

Such pay clinics should aim to serve self-supporting families of limited means, particularly in the specialties. There is much need for the further development of such clinics in Cleveland.

The admission system in connection with pay clinics should protect the interests of the medical profession as well as of the patient by adopting and carrying out the standards above outlined.

(*d*) REMISSION OF FEES—The admission desk in the smaller dispensaries should be responsible for the remission of all fees. In large dispensaries the admission desk may be unable to attend to all remissions in the case of old patients, and social workers in one or more clinics should be authorized to pass on remissions for the appropriate group of cases.

Adaptation of Clinics to Clientele

(*a*) HOURS—Evening clinics for working people are desirable in all or almost all dispensaries. These clinics may well be pay clinics.

(*b*) FOREIGN-SPEAKING PATIENTS—Special efforts, as outlined in the discussion of the foreign-born, in the section on the "Human Problem of the Hospital Patient," should be made to enable persons not speaking English to receive effective treatment.

(*c*) One important group of the clientele of nearly all dispensaries is that of the beneficiaries of other charitable or medical agencies. It is part of the duty of a dispensary to serve as the family physician for these. This requires: (1) examination of patients and families and full reporting of conditions found to the society interested; (2) treatment of those needing care, usually without fee; (3) special arrangement whereby the social service department of the dispensary has charge of "steering" these cases and insuring that the work is done and the reports are rendered with a minimum of administrative demand upon the clinic physician.

(*d*) The dispensary should be a main agent in the admission of hospital patients to the wards and in the follow-up of those discharged. (See sections on Convalescent Care.)

Inter-relations of Dispensaries

(*a*) DUPLICATION—The pursuance of treatment by a patient or the members of a family at more than one dispensary at the same time should be discouraged and prevented as far as possible by careful admission systems. The inquiry at the admission desk should include question as to place or agency of previous treatment.

(*b*) REFERENCE OF PATIENTS—Patients recently under treatment at one dispensary and not specifically referred to another for consultation, should be referred back to their former place of treatment, except when satisfactory reason is found to exist for the transfer. The same policy should of course be pursued when a patient has been under treatment by a private physician.

The use of printed or written slips of reference is of practical service.

(*c*) DISTRICTING—The limitation of the work of each dispensary treating the sick to a definite area is not practicable, but patients should be encouraged to seek treatment in the section of the city in which they reside or have their place of business. Well administered admission systems at each dispensary and a common understanding of policy, worked out by the proposed central committee, should reduce to a minimum problems of duplication and of overlapping of areas.

Dispensary Administration

Essential points of organization are presented in the sections on "Organization for Service" and "The Medical Profession and the Hospitals," and will be merely recapitulated here:

An executive head for the dispensary.

A medical organization which is integrated with that of the hospital.

A dispensary medical committee.

A dispensary committee of the board of trustees or, if the board has not a sub-committee system, one or more members of the executive committee who have special responsibility to be in touch with the dispensary.

The dispensaries of Cleveland would do well to develop carefully worked out systems of referring patients from clinic to clinic within the dispensary, for consultation purposes; and for transferring patients for treatment from one clinic to another, with due report back to the referring or transferring clinic.

The important place of the social service department in dispensaries is outlined in the section devoted to social service.

Medical Care of Children in Foster Homes

This has received little attention from the medical agencies of Cleveland, and the Humane Society itself has not dealt adequately with its responsibility in this matter. As Dr. Mac Adam's report shows, in another portion of the Survey (Part II.), the physical condition of the children boarded out by the Humane Society is far from satisfactory. Moreover, the Society's records do not show adequate medical supervision of its children, and indeed the system which it pursues would render adequate medical work quite unlikely. Even in the case of the children under three years of age, which are within the special province of the Babies' Dispensary and which are supervised thereby in behalf of the Society, results are not satisfactory. This is largely because of the lack of a really intimate affiliation, which is required for the successful conduct of any such piece of work. It is essential that the physicians of any dispensary which is served in such a capacity shall think of the special problems of a placing-out society, as well as of the physical needs of each individual baby. The social workers and nurses who are in touch with the foster home need special explanation of the child's needs in terms that they can understand, and the foster mothers need instruction not only from the field workers but also, from time to time, from the physician himself. Moreover, the administrative system of the dispensary must be specially adapted to this work for the placing-out society. Delays must be minimized and records and information be readily and promptly secured.

In the case of the older children, present conditions are still less satisfactory than with the babies.

Satisfactory results cannot be expected unless the Society has a Medical Director, who should be a specialist in pediatrics, and be responsible for the medical standards and policies of all children under the care of the Society. This director should be a member of the staff of the children's clinic of a dispensary with which the Society makes a working arrangement for the initial examination, re-examination and much of the interim supervision of the children's health. Preferably he should be also on the staff of a hospital with a pediatric service so that sick children requiring hospitalization could be still under his care. There are substantial advantages in utilizing for examination and supervision the equipment, organization and the group of specialists of a well managed dispensary, instead of a number of doctors in separate private offices. The systems worked out in Boston, by cooperation between the Children's Aid Society and the Boston Dispensary, and in Philadelphia by the Seybert Institution, could be studied to advantage as illustrations of method.

It is important that there shall be not only intimate coordination between the medical authority of the Humane Society and the medical agents and agencies doing the actual work, but also that the nursing and social service staffs be in similarly close touch. Without this, satisfactory results cannot be expected. The medical workers and the field workers must understand one another and the system under which each group works must be mutually adapted to achieve the needed degree of mutual understanding.

It is recommended that:

1. A medical director, a pediatrician, be appointed by the Humane Society, with a financial honorarium, as the authoritative guide and supervisor of the physical condition and development of all its children

2. This director be a member of the staff of either the Babies' Dispensary or of the proposed central downtown dispensary (Pediatric Clinic), whichever the Humane Society decides to be the better organization for such affiliation.

3. Routine medical examination, re-examination, advice and supervision of health be carried out through the selected clinic, a special salaried medical assistant being requisite for the purpose. The Humane Society should provide this salary.

4. Standards for medical examination, hygienic directions, diet, re-visits, home care in emergencies, etc., be outlined by the medical director.

5. Consultation by the specialists in other departments of the selected dispensary (eye, dental, throat, ear, skin, orthopedic, etc.) be provided as requested by the medical director; treatment also as necessary.

6. The use of the local doctors and of specialists in private offices be reduced to a minimum; that reports from such physicians be required and made part of the central medical record.

7. A special worker be in the selected pediatric clinic, under the administrative direction of the clinic, but with salary wholly or largely from the Humane Society, to attend to the details of assisting in securing examinations and consultations; in effecting transfers; keeping track of needed re-visits; and seeing that the necessary information is furnished by the Society to the clinic doctors and workers on the one hand, and by the clinic to the field workers and foster-mothers on the other.

8. Periodic conferences between the medical director and his assistant or assistants, be held with the clinic worker and the field nurses and social workers who deal with the Society's cases.

9. The records of the clinic concerning each child be regularly furnished the Society and the clinic be provided by the Society with such history of each case as the medical interests require. Record forms should be especially prepared for this purpose.

10. The present system of utilizing public health nurses for home visiting of placed-out children be continued and made much more effective through (a) the centralized medical direction contemplated in the plan (b) the closer medical supervision provided for in recommendations 3, 7 and 8.

If the Babies' Dispensary will increase its age limit and render its organization sufficiently flexible and adaptable to meet the requirements of efficient service to this group of children, it would be desirable that the plan be worked out by the Society in cooperation therewith. The establishment

of some special clinics as well as the general pediatric clinic would be necessary, as the Survey has recommended in its special report to the trustees of this institution. If the requisite conditions cannot be met at the Babies' Dispensary, it is recommended that the central downtown dispensary be utilized.

It should be pointed out, in conclusion, that while the proposed plan for adequate medical supervision of placed-out children will cost more than the present admittedly inadequate system, the expense of the medical work is after all only a small fraction of the total cost of boarding and general supervision of such children. Very little permanent result for the present or the future generation can follow from any system of children's aid which does not make the thorough and efficient care of health a primary consideration.

DISPENSARY NEEDS OF CLEVELAND

Aside from the public health dispensaries for which recommendations were made in the previous section of the report, the dispensaries for the treating the sick of Cleveland universally need improvement in various respects. Recommendations regarding each institution have been presented to its governing body by the Survey. In general, the needs may be summarized as: (1) more work to be done; (2) better executive direction through the assignment of a definite officer to be in charge of the dispensary, under the superintendent; (3) representation of the out-patient department so as to secure better recognition of it by the hospital authorities; (4) paid assistants for the medical staff (social workers, nurses, clerks) so as to relieve the physicians of non-medical drudgery and improve the grade of service to patients; (5) better records which, would largely be accomplished by the assistants just mentioned; (6) better plants and equipment.

The expense involved in the improvement of services lies chiefly in the salary of the paid assistants mentioned, and would be largely met by the admission fees recommended.

An increase in the amount of dispensary service for the people of Cleveland is as greatly needed as is an improvement in the quality of service now offered. It may be expected that the work of existing dispensaries will increase considerably as more attention is paid to their needs, and better support is provided. But no increase in the work of the six present institutions can obviate the necessity of at least the following additional dispensaries:

The City Hospital out-patient department is already provided for in the tentative plans for the enlarged City Hospital. It should be one of the major dispensaries of the city. (See section on "Community Planning").

St. John's Hospital should, as soon as possible, develop a good-sized out-patient department for the benefit both of the hospital and of the west side area which it especially serves and which now has no dispensary.

When the re-organization and development at St. Alexis Hospital have been worked out under the new advisory committee, the establishment of a

well-equipped out-patient department should be undertaken and this need should be borne in mind by the committee even in the formulation of its plans for the immediate future.

The establishment of an out-patient department, now being built by Fairview Park Hospital is approved, although this dispensary will probably remain small and its work restricted largely to certain types of cases, particularly surgical, corresponding to the work of the hospital.

The same would probably be true of similar out-patient departments that might well grow up in connection with other hospitals of the same type in the same section of the city, such as Grace Hospital or Lutheran.

The plans for the re-location of Lakeside Hospital imply a new dispensary, attached to its new plant. This should be another of the few major dispensaries, as described in the community plan, in the section on that subject.

The proposed new plant of St. Luke's Hospital will require a dispensary, unless the present buildings or parts thereof, are retained as an industrial hospital, and a dispensary be operated in connection therewith. The latter plan is recommended.

It is not believed that the proposed new plant of Huron Road Hospital on Ambler Heights will require a dispensary for some years to come; but Huron Road might with advantage have at least a medical affiliation with the proposed central downtown dispensary. (See section on downtown dispensary.)

A new dispensary will be needed downtown, at least as soon as Lakeside and Huron Road move out, and meanwhile, certain services for the downtown area need immediate development.

Cleveland, like most other cities, suffers from lack of any general plan for dispensary service. The different clinics are not coordinated with one another or with the public health and charitable agencies. It is essential to have a plan and effective organization whereby the work of existing dispensaries shall be improved and the new dispensaries be established in sections of the city now unprovided for. But above all, the aim must be to furnish a basis upon which dispensary service should be better understood by the community and better serve the community. The points of view of the practitioner of medicine, of business, and of charitable agencies, of the men, women and children who need adequate service and cannot pay for it, and of the public as a whole, represented by the city government and organized agencies for expression, all need to be considered in framing any forward-looking project of this character. The preventive and educational work of the health centers must be adjusted in conjunction with the curative medical work of the hospital out-patient departments, so as to be mutually helpful and to serve as parts of a developing city plan.

It is necessary—

(*a*) To create some group of people or machinery whereby the dispensary problems of the city can be viewed as a whole, each particular dispensary or related agency be brought into touch with the larger problems, and the larger problems themselves directly and adequately dealt with.

(*b*) To have dispensary work rest upon its own financial basis—the financial support of dispensary service being provided in terms of and in proportion to such service, and not merely as a part of hospital or medical work in general.

It is therefore proposed:

1. That there be a Dispensary Section or Committee of the Hospita Council—this committee or section to include representatives from each of the existing out-patient departments of those hospitals which are members of the Council; and also representatives from the Department of Public Welfare, the Cleveland Academy of Medicine, and persons interested in visiting nursing and charitable agencies.

2. That there be a salaried executive officer for this Dispensary Section or Committee of the Hospital Council. Such officer at first might be required only for part time and in that case had best be selected from some organization other than one of the privately operated out-patient departments.

3. That the Cleveland Welfare Federation require the presentation of request for support for the out-patient departments of hospitals to be made separately from the request for support for hospital work proper; such requests to show the work done by the dispensary, the cost thereof (including a fair allowance for overhead) and the income of the dispensary from fees paid by patients or from other sources.

In view of the general importance of dispensaries to the community, and of their special service as the "family physicians" of the non-medical charities, the Welfare Federation should appropriate monies to dispensaries (the out-patient departments of hospitals) on the basis of reports of (1) work done, (2) gross expenses incurred, (3) net expense after deducting all dispensary income from fees, special endowment, etc. This would mean a consideration of the annual dispensary budgets as separate parts of the budgets of the hospitals to which the dispensaries are attached. It would cause appropriating, supervisory and administrative bodies to give much more attention to the dispensaries, which have too often been regarded as merely incidental elements in a hospital.

Cleveland ought to have at least three times as much dispensary service as it now has. In from three to five years this goal can be attained, through the enlargement and improvement of existing dispensaries and the addition of new ones at the City Hospital and on the west and south sides. The gross cost of adequate dispensary service to Cleveland, at present costs of

maintenance, would probably be over $300,000 annually. The present gross cost is not over $75,000 (charging in all overhead). The difference is due partly to the limited amount of work and partly to low standards. It should be expected that when proper fee systems are developed, 50 per cent. of the gross cost should be met by fees from patients.

It is thus contemplated that the Dispensary Committee or Section of the Hospital Council should be an expert advisory and planning body, serving to improve dispensary standards and administration of the several institutions; to work out the larger problems of policy and inter-relation, and to serve also as an advisory body for the Welfare Federation, as the Hospital Council now does. The financial standing given to dispensary work by the proposed action of the Welfare Federation would be essential if dispensary service is to stand on its own feet.

No such Dispensary Section or Committee could be effective unless some definite salaried executive assistance is provided.

More and better dispensary service is one of the important medical needs of Cleveland. The Hospital Council and the Welfare Federation should recognize it as such.

THE CENTRAL DOWNTOWN DISPENSARY

The central downtown district of the city presents needs for medical and health service which are now not met, and offers certain unique opportunities for rendering many forms of service. Huron Road Dispensary is excellently located, but the present dispensary is very small, and is in cramped quarters which permit but slight expansion, while the hospital continues as at present. Lakeside Dispensary, while not as well located, though still fairly accessible to the central downtown area, has far more possibilities, but as yet has not measured up to its opportunities. The moving out of both of these institutions will require either the retention of one plant as a central downtown dispensary, and the maintenance in this plant of needed forms of service not now provided, or the establishment of a new plant.

In the first place, it is desirable to state the needs to be met. The central downtown district of the city requires dispensary service within its own area for at least four reasons:

(*a*) Emergency and industrial surgical work arising from the large daytime commercial and industrial population of the central area of the city.

(*b*) Many special forms of medical services which for the public welfare should reach as many persons as possible, and which in the downtown area can be brought to the attention of the large daytime and evening population which throngs this district for business or recreational purposes. Clinics in this district held at certain hours of the day, for instance at luncheon time and in the evenings, would reach large numbers of persons who are practically inaccessible otherwise. Tuberculosis Clinics, Venereal Clinics, or Mental Hygiene Clinics, are examples.

(*c*) General medical and also special services such as are provided by general dispensaries, ought to be available to this transient population of the central area (as well as to its residents) at hours and under conditions which would make it possible to have these services most effectively used by those who most need them.

(*d*) This dispensary would serve charitable agencies, providing medical examination and supervision for the families under care in the central district, or who have to be brought to this district to the society's offices. Cases requiring elaborate study or special treatment would be referred to one of the major out-patient departments.

The downtown dispensary is required for a larger reason. If properly organized and made a real center of a variety of health and medical activities such a downtown dispensary would serve as an important educational center along general health lines, assisting the work of many other agencies, not only as a point from which patients would be referred but also as a center of public health education.

Such a dispensary would include:

(*a*) A clinic for industrial surgery operated throughout the twenty-four hours. Such a clinic would require special arrangements for its professional services and be administered so that patients could be admitted without delay, although the clinic might be closely related to the other dispensary services in the same building. The need for such an industrial clinic has been brought out in Part VII. of the Survey Report.

(*b*) A Health Center of the City Division of Health maintaining (1) a tuberculosis clinic, with a special consultation service at periodical intervals, (2) venereal clinics, and (3) a division for health education, which should include among its activities the conduct of a clinic for the examination of well people—children and adults. It might perhaps be best to maintain the venereal clinics under private auspices. (See Part V.)

(*c*) A mental hygiene clinic.

(*d*) A general medical clinic for the examination and treatment of sick persons.

(*e*) Special clinics, such as eye, ear, nose and throat, and surgery, (other than industrial surgery).

(*f*) The "Orthopedic base" or "center" recommended in the orthopedic plan, (Part II of the Survey Report), should be in the same building. Its work would assist all the other branches in the downtown dispensary and would be assisted by them. This orthopedic center would include, besides certain administrative functions relating to the orthopedic plan of the city as a whole, a physical treatment center which would be of city-wide value and would be especially advantageous if located in this central district.

(*g*) The affiliation of this downtown health center with the University is highly desirable.

It has been pointed out elsewhere that there is needed a certain small number of hospital beds (20 to 50) in the central downtown area, largely for emergency purposes. This emergency hospital or "relief station" could with advantage be combined with the central downtown dispensary.

If both Huron Road and Lakeside Hospitals move to their new sites within a few years the proposed dispensary and the emergency beds will be the more urgently required. The plant of Huron Road Hospital appears to be suitable, with relatively slight modifications, for the combined purposes of emergency beds (30 to 40 in number) and the downtown dispensary. The location is almost ideal. It might be well for Huron Road Hospital, as well as for the public good, that there be a medical affiliation between the Huron Road staff and the dispensary staff; but the problem of staff for the downtown dispensary might be solved in other ways.

The industrial surgical clinic should be fully self-supporting, from the industries which it serves and from the workmen's compensation cases. The

staff of this division should be salaried. The senior visiting staff would provide certain supervisory and consultant advantages.

The public health clinics of the dispensary would constitute an additional Health Center of the city Division of Health, and would require the necessary addition to its budget. The mental disease and mental hygiene clinic should be maintained, at least at the start, by the organization especially concerned with this interest. The orthopedic clinics and physical treatment center should be supported likewise by the orthopedic group referred to elsewhere in the Survey report (Part II.)

The Community Fund would properly be called on for the financial support of the general medical clinics for adults and for children, and for the special clinics which are required. Not only as meeting a general public need and a broad purpose in health education, but also as assisting charitable societies to secure better medical examination, advice and supervision for their beneficiaries, the central downtown dispensary has a peculiar demand upon the Welfare Federation. This dispensary, among other benefits, would make money spent for many other charitable agencies count for more.

In estimating the cost of this dispensary, it must be borne in mind that the medical staff in all clinics should receive financial compensation, except for merely consultant or infrequent visiting services. The gross maintenance expense of conducting the industrial surgical clinic, public health clinics, general medical, pediatric and special clinics, with a used capacity of 50,000 visits a year, should not exceed $60,000. Deducting the cost of the industrial and the public health clinics supported by industry and by the city, respectively, the gross charge upon private funds would be about $35,000, of which some $15,000 might be expected to be returned through fees from patients. The net charge should not exceed $20,000 a year.

It is apparent that the initiative in putting this dispensary under way must come from some privately organized group having a special interest in the matter. It is recommended that shortly after the proposed Central Dispensary Committee has been organized, this committee initiate discussion of the matter and call together a conference of such individuals and interests as may be necessary. Some one committee or organization would have to assume definite responsibility for the plant. This committee might be a joint body of the organizations providing various services, or a more specialized body which made arrangements with the other groups to use the plant for certain purposes at specified times. The plan will be restricted in its service in proportion as few activities are included, and will be broad and far-reaching as the number of activities and interests is increased, always assuming their harmonious coordination. The combination of the public health and preventive clinics with the curative clinics, for instance, is of vital importance.

It would not be unnatural that Lakeside or Huron Road, particularly if their moving plans are delayed, should suggest that their present dispensary be the basis of the proposed central dispensary. Such a plan is not impractical, provided there be sufficient flexibility and readiness for cooperative

adaptation in the existing organization which is made the basis. It will be well to remember that such a central dispensary represents a Health Center in a somewhat advanced sense of the term; that it might ideally contain administrative offices of public and private health agencies, meeting rooms and auditoria for public health education; and stand before the people of the city as a visible expression of the communal interest in health. Through its own activities, in which curative and preventive functions should be correlated, and through its connections with the Central Dispensary Committee, the municipal health work, the business, educational and philanthropic interests, the proposed dispensary might be a constructive force as well as a service to many individual lives. Only by grasping the possibilities of the project in the future can any institution or any committee justify an assumption of responsibility for its leadership in the present.

IV. Special Problems

THE CONVALESCENT AND THE HOSPITAL

By MARY STRONG BURNS, R. N.

INTRODUCTORY NOTE

Mrs. Burns, as a member of the staff of the Survey, presents in this chapter a study of convalescent patients recently discharged from the hospital. Few if any cities have as yet met adequately the need for convalescent care. The most notable work in the country is that of the Winifred Masterson Burke Foundation at White Plains, New York, under the direction of Dr. Frederic Brush, whose significant contribution as collaborator in the Cleveland Hospital and Health Survey will be found in the next chapter. The bulk and general bearing of the convalescent problem in Cleveland is discussed in that place.

Mrs. Burns' contribution is a series of vivid pictures of what may happen to patients after they leave the hospital doors, and drives home the point that a sick man's sojourn in the hospital is only one stage in the journey between illness and health. Too easily does the hospital forget this truth. Too often do hospitals in Cleveland as elsewhere feel or at least act as though they felt that their responsibility ended when "discharged" is written on the record and the patient is no longer within the building.

The care of convalescents is a much larger problem than that of a hospital or institution for convalescents. The bulk of convalescence takes place in the home, and particularly in medical cases, the whole course of the illness, from onset through acute stage, convalescent stage, and final restoration to health and vigor, may take place within the home. From this broader standpoint of the community, the convalescent problem is approached in the following chapters.

In Mrs. Burns' study emphasis is laid upon the hospital patient and his need after discharge. Her very practical recommendations should be compared with what has been said in the chapter on the Human Problem of the Hospital Patient, with reference to hospital provision at the time of discharge and the use of the dispensary therewith.

A STUDY OF HOSPITAL CONVALESCENTS IN THEIR HOMES

In attempting this study two things were very quickly apparent: (1) that convalescence is as much a state of mind as of body, and that environment which does not provide for the needs of both is inadequate; (2) that the background of convalescence is laid, the texture of it stretched and woven, while the patient is still lying abed in hospital. His mind is a sensitive shuttle threading with tireless insistence every impression of the hospital ward, whether grave, radiant, trivial, or profound, and coloring each with his mood of the moment. On the "date of discharge" (when shall we find a more gracious phrase?) the patient takes this mental "sampler" and during the time that he must "remain inactive" as the house physician says, he wonders over it all. If left to himself he makes few alterations in this plan of return to health which the hospital has spread

out for his interpretative copying. Every impression is traced and retraced and his conception of health and of his part in holding it is framed in his idea of hospital service and remains pictured as a never-to-be-forgotten experience.

In seeing over two hundred such "pictures" one could often exult that the hospital had been interpreted favorably and with gratitude. When the interpretation had been distorted through mutual distrust and misunderstanding, regret was always followed by the conviction that a broader conception of the hospital's responsibility was possible, indeed necessary, and that it would more and more make the way straight for patient and hospital alike. Two points of view will illustrate: (1) A Polish woman, after three weeks in a hospital ward, thus voiced her opinion on the Hospital Bond Issue, "She is like a great and wonderful mother who cares for many sick children, this City Hospital. If more money she needs let us say yes and give." (2) A man sensitive at being temporarily without money bitterly resented the hospital's attitude that he should pay his bill there because he had hitherto paid his private doctor, "Why would they think I should go to that place if I could any longer pay a doctor? Would anyone go who did not have to? I burn with shame when I think what questions they ask."

Thus convalescence is the state of mind and body on which the hospital may set its stamp as a friend and helper or as an autocrat without sympathy. The real service to the patient is but half done on the date of discharge. The test then comes, to decide whether the final stage of convalescence shall be to each of its patients a stimulating, worth-while experience or a lonely and difficult task to be faced against great odds.

The cases studied were two hundred discharged patients from four of the principal hospitals of Cleveland: Charity, City, Lakeside, and Mount Sinai. They were nearly all classified as free or part-pay patients. A few had apparently paid the full charge for treatment. They included a variety of foreign nationalities, of which Cleveland offers many: Armenian, Australian, Bohemian, Chinese, Greek, Italian, Lithuanian, Polish, Slovenian, Swedish, etc., a number of native American whites and a fair proportion of Negroes. The environment of patients seen ranged from that of wretched housing and extreme poverty to the completely comfortable house of the well-to-do.

The types of illness from which these patients were convalescing were contagious and general diseases, surgical operations and accidents. There were also a few maternity cases. Their length of stay in hospital varied from five days to two months.

Half of the cases were seen within three to four days after discharge. The others were seen within ten days after discharge with the exception of six surgical cases who had been told not to resume work for four weeks.

In the homes the reaction of the hospital upon the patient was noted: (1) whether the diagnosis and medical advice had been understood, and was being followed with satisfactory results; (2) whether assistance of any sort

would more certainly assure the result for which the hospital had worked. In a word, was the best sort of convalescence possible for that particular patient in that particular home?

The convalescents seen were classified as follows:

Cases with Home Environment	Total Cases	Total Per cent.		
1. Favorable and adequate	25	12.5		
2. Favorable with minor adjustments, economic or personal	71	35.5	59.5 %	
3. Unfavorable but remediable by economic or other assistance	48	24.0		87.5%
4. Unfavorable and not remediable, needing institutional care in convalescent homes	44	22.0	28.0%	
5. Acutely needing further hospital care — relapse after return from hospital	12	6.0		
	200	100.0%		

Thus, with only 12.5 per cent. in suroundings favorable and adequate for convalescence, the remaining 87.5 per cent. of these cases returned to homes which were unfit in varying degrees for their convalescence. With proper advice or assistance, conditions could have been remedied in about two-thirds of these cases (59.5 per cent. of the total number) while with the other third (28 per cent. of the total number) conditions were irremediable and the patients required institutional care in convalescent homes or still longer care in hospitals.

Charity Hospital

Considering the convalescent cases of each individual hospital as a group, those of Charity Hospital presented the following distinctive characteristics:

Cases with Home Environment	Total Cases	Total Per cent.
Favorable and adequate	15	30.0
Favorable with adjustments	21	42.0
Unfavorable but remediable	6	12.0
Unfavorable and not remediable	6	12.0
Acutely needing further hospital care	2	4.0
	50	100.0%

As permission was given to choose the patients from the complete files of those discharged there were by chance more pay or part-pay patients and among these were people of intelligence and personal capability who

had been able to adjust their homes to provide adequately for convalescence. This had sometimes been accomplished by pre-arrangement, before going to the hospital, with some competent friend of the family who possessed the special mental or moral force needed for the situation. (It was noticeable that this force was as often absent in the more prosperous homes as in those of otherwise discouraging surroundings.) Practically no form of social service had been offered to this prosperous type of patient, but the patient's evident appreciation of the idea as a possibility was impressive.

The prevalent feeling among the 82 per cent. of operative cases among women was that they had had the benefit of wonderful surgery, but were no wiser than before the operation as to what had been the matter with them or what was to be done to prevent further difficulty. The "head doctors" or attending surgeons were described with awe, yet regret, as "too important to be bothered"; "he's so busy he can't listen"; "it seems he's not the kind of a man to give you much talk."

A gynecological case returned to her home without instruction from the hospital, and within two weeks had housecleaned her tenement, painted furniture, papered two rooms, and was doing the cooking under a sloping ceiling too low to allow her to stand upright at the stove. The doctor having said she was "all right," she did not understand how she felt worse than before the operation. Concluding it was all a failure, she had begun treating herself with Lydia Pinkham's remedy because the newspapers said it would help anyone who felt as she did and she didn't want to waste any more money on the hospital.

Another operative case returned weak and wondering why the old pain was just as bad, while all she "could get out of the nurses and doctors was that they had gotten what caused the trouble." Still another, in a wretched but pathetically neat tenement, lay abed, mystified at feeling worse than ever before, while the family questioned her, "What happened? Have we paid $86 for this?" The cost in money loomed larger than any visible return in health.

Of the women who were uninformed as to their condition only one had not asked to know. At seventy years she was tranquil and not inquisitive.

The men also had doubts. A neurasthenic, aggrieved at the little attention bestowed upon him at the hospital, had gone home to a combination of quack electrical treatments and doses of No. 99 at Doctor Simpson's Medical Institute. His protest was, "Why didn't the doctor say what *would* do me some good?"

Another came home to wretched lodgings from a long siege of lead-poisoning, pneumonia, and an operation for empyema. While he was explaining that the incision had been allowed to close too soon because the hospital was short of beds, the doctor who had sent him to Charity Hospital came to take him to St. Alexis, there being a vacant bed where the surgeon who had operated first would open up the incision.

A man, whose money was low after seven weeks in the hospital, was travelling a distance of seven miles for dressings because he knew a doctor who would not charge much.

A sturdy Irishman with facial paralysis after a mastoid operation was embittering his days with thoughts of sueing the hospital, while his wife wailed, "Sure, they have destroyed him entirely. 'Twould draw tears from a stone."

The White Motor employes who after leaving the hospital were cared for at the dispensary of their works, seemed well informed except in the case of one man. A dressing of his foot had not been changed for four days. Having been told that he was "all right now," he had taken this literally, until the pain and swelling led him to doubt. He had recently been burned out of his home, and as the only support of a wife, mother, and five children under twelve years, had gone on a ten-hour night shift to get the extra pay of $11.85 a day. He was slowly coming to the conclusion that his foot, by its delayed recovery, was costing more than his hospital bill.

SUMMARY OF CHARITY HOSPITAL CONVALESCENTS—Since hospital service dominates convalescence to such a degree that it has no present but only a past, these cases have indicated: (1) That more nursing care, if only for its educational value, and better night service, particularly for men, should be offered. (2) That more time should be given to instructing all types of patients as to their part in carrying on convalescence, returning to dispensaries or physicians, etc. (3) That after-care in the homes is often indispensable. (4) That there should be more real interpretation through Social Service of the problems of foreign-born patients, so that "Tony" would not have felt it possible to get out of bed and walk off without saying, "By your leave." (5) That the cash value of health should be explained to those patients who reluctantly offer their fees. With the help of Social Service every patient should be made proud to contribute his charity to the common good.

City Hospital

City Hospital presents the following showing:

Cases with Home Environment	Total Cases	Total Per cent.
Favorable and adequate	5	7.0
Favorable with minor adjustments	19	26.8
Unfavorable but remediable	21	29.6
Unfavorable and not remediable	20	28.2
Acutely needing further hospital care	6	8.4
	71	100.0

The large portion of those having unfavorable and irremediable surroundings corroborated the superintendent's statement that almost half of

their patients have no homes and must be kept in hospital until ready for work, the only alternative being the Warrensville Infirmary.

Even a superficial contact with the various types of lodgings, rooming-houses, and rooming hotels, with their forlorn attempts at light housekeeping, brings swift conviction that they can never offer a fair chance to convalescents. The atmosphere of isolation, the indifference as to what happens to the lodger after he pays for his room, the long flights of stairs to be reckoned with whenever a meal is needed—these, aside from the unwholesome living conditions, proclaim the lodging system as "fatiguingly futile" for convalescent use. The patients themselves evidently realize this fact and many did not return to their given address. Others had never lived at the given address, but had been known to the owner of the lodging house or to some of the lodgers. A few gave an impossible street number selected with evident care. The Salvation Army, the City Mission, a corner store, or a former saloon will sometimes be given as an address where nothing definite could be remembered of the patient. One man was found on the corner near the restaurant which he had given as his address and explained there was "generally some one round that corner who knew where he hung out." Such were the frail links to home and the greater reasons for convalescent care in institutions or at least for continued hospital supervision.

Another tremendous claim for convalescent supervision of the most far-reaching and efficient sort was made by the fact that many other patients came from *homes* which were totally unfit for convalescence or continued health, unfit for the minimum requirements of normal living—on the edge of the dump, in gullies thick set with smoke, in leaky shacks—the cracks stuffed with newspaper and the room reeking with kerosene fumes, in dark tenements, four or five of which would open on a court filled with the accumulated refuse and garbage of the winter, where the convalescent child was left to "play."

The hopeful note in many instances was the persistence of the family in keeping its tenement clean within in spite of the disheartening mess without.

In several such homes on Orange Avenue there was as keen an interest and sense of personal concern in the Survey of the Hospital Council as at a Chamber of Commerce meeting, thus bearing out the idea of Doctor Frederic Brush on convalescence that "health service should be offered where people live and work and play.* * * Of abiding value in this period of convalescence is the process of *normalizing*, in all ways which may hold throughout life."

It is hard to prove which will finally claim the most patients, the influence of the hospital or that of the home on the edge of the dump beset by every health hazard and bereft of every help to sanitation, but it is only when Social Service shall present overwhelming evidence of the limitation of hospital skill before such handicaps that these entirely eradicable conditions will be swept away.

The surgeon, who has conscientiously given his intelligence and skill to renew life, should realize that the condition of the home to which he is send-

ing his patient, will play a vital part in the final success of his work. To have a mind to insist that dwellings and their surroundings should be fit for the minimum requirements of ordinary living would be to open up many possibilities in home convalescent care which, as yet, are untried, and the importance of gain in the general health of the community and in health education, should not be overlooked.

Still other types bespeak the follow-up work of the hospital. The drug addict, returning to lodgings with little moral support; the child with chorea celebrating her home-coming with a "regular meal" of coffee, sausage and pie; the heart case who has spent most of his small life in hospitals and pleaded, "Oh, Muz, my business is always hospitals! Can't I stay home and get well?"; the fourteen-year-old runaway with mumps whose pride had thus resented his being put in the "kids' ward" where his feet stuck out through the bed-bars; the child of five whose mother had never been able to find out from the hospital what its illness had been—these and many others proclaimed their necessity for further care without which a large part of the hospital's work goes for naught.

SUMMARY OF CITY HOSPITAL CONVALESCENTS—These cases present the following well-defined needs: (1) Increased institutional convalescent care; (2) Instruction of patient at discharge; (3) Social Service, to adapt the homes of patients for convalescence therein.

Lakeside Hospital

Lakeside Hospital showed:

Cases with Home Environment	Total Cases	Total Per cent.
Favorable and adequate	4	7.0
Favorable with minor adjustments	21	36.8
Unfavorable but remediable	14	24.6
Unfavorable and not remediable	16	28.1
Acutely needing further hospital care	2	3.5
	57	100.0

The cases were offered with ample records and in the spirit of the fullest cooperation. Probably because of this it was more noticeable that the instructions to patients by the doctor were most often "none in particular" or "return to dispensary."

The "none in particular" probably indicated that to the doctor the case did not stand out in his mind as needing any instructions other than those of routine convalescent care after a pneumonia, a laparotomy, or whatever else the disease or operation might be. The patient, however, assuming this role for the first time, finds everything strange about being "a pneumonia" and things stranger still as "a laparotomy." He is full of interest in himself. He wants to make a success of getting well and there are many questions to

which he wants to know the answers. He is hoping there will be time for one of the doctors to have a talk with him about it all before he leaves the hospital. But often the last day comes unexpectedly, his bed being needed for a more urgent case, and he finds himself at home several miles from the hospital, wondering why he managed to find out so little of what the hospital knew so well. When special instruction had been given the patient on discharge, the effect was almost magical. To have been instructed to carry on what the nurses have begun, to have responsibility for one's own treatment, gave a new zest and importance to convalescence. Particularly was this noticeable in patients who were returned to the dispensary for the treatment of syphilis. Alert and intelligent, they were too much in earnest to be self-conscious and presented convincing evidence of wise and inspired teaching. With the exception of these cases there was little evidence of hospital Social Service other than visiting nursing among the patients seen from Lakeside.

The ambulance experiences of many held a large share in their convalescent thoughts. The negro who, after an automobile accident, regained consciousness in "Hogan's dead wagon," "don't never expect to get over that wake up." He thought he was being taken to the undertaker's establishment as dead. Often neighbors have "chipped in" to collect the money for an invalid carriage so that the police emergency need not be called, and with a naive idea of gradual descent to the mundane, some announced that in leaving the hospital, they took a taxi to the nearest car-line and transferred to the trolley for the rest of the way home.

Another impression noted among the women was remembering the fatigue of that first complete dressing to leave the hospital. Apparently this was often done without assistance as the nurses had other duties and the friends of the patient were not allowed to come to the ward. (This was also noted in patients from other hospitals. An old negro woman with an aortic aneurism was being sent home from the City Hospital on the ambulance stretcher. She described the fatigue of preparation and added "The head lady nurse told them, 'Don't bother if it is a hospital gown—let her go while the spirit is in her.' I sure was grateful. She certainly had wisdom, that lady nurse.")

Two other shadows of convalescence were: (1) the long uncertainty and final disappointment over the amount of the hospital bill, and (2) the fact that patients sometimes came away resentful because they had been the "interesting case" used to teach others. They felt that they were being detained in hospital for this purpose.

These may seem minor details in the immense and complex scheme of administration which the hospital must embrace, but with the sensitive imagination of one half sick—"behold, a little cloud ariseth" and the whole of his convalescent sky is darkened.

The amount of the bill could be approximately decided before the day of discharge and preferably nearer the day of admission so that this "indeterminate sentence" might be cleared up. If the patient has not been able to

pay, it is perhaps not the happiest sort of *envoi* to have "the last one you see at the front door saying, 'I hope you will be able to work soon and pay your bill.'" Social service at the front door might perhaps have given the deft touch to incentive which would have brought the patient to say as much *for himself*, with gratitude and courage.

Again, in the matter of the resentful "interesting case" the house physician who is a vital influence for energizing convalescence, could in a few words, with perhaps a touch of cameraderie, present the idea of an impersonal yet chivalrous appeal for humanity, and the patient might become at once the "*interested* case," ready and a little grateful to contribute to the advancement of clinical medicine and scientific research.

The foreign-born patients who had had bedside lessons in English in the hospital and who had heard their own language understood and translated by a sympathetic interpreter, beamed with appreciation at the remembrance. This happy cooperation with the Board of Education can be developed so that the often empty hours of convalescence will be brimming with interest.

SUMMARY OF LAKESIDE HOSPITAL CONVALESCENTS—Almost without exception the Lakeside cases showed that the completion of the hospital's work can only be accomplished outside of the hospital and through the extension service of social work.

Whether this is rendered in the guise of institutional convalescent care or of home service, there is every indication that the expense would be less than a protracted stay in the hospital. The patients are quick to testify that after the first urgent need of acute illness the hospital atmosphere is not helpful. Its ceaseless movement is too intense and vivid for rest.

To the patient with a problem waiting at home, institutional convalescence, however luxurious, has little charm—"For what good should I go away. The worry for the kids would go with me," said a mother amid a clutter of babies, washtubs and general disorder. "This is the best for me here." Her peace of mind arose triumphant over the scene of distraction, for her problem was within her grasp.

The unanimous opinion among such convalescents was that any help in household administration would be welcomed.

Mt. Sinai Hospital

The cases referred from Mt Sinai came to the investigator slowly and were possibly a more or less expurgated edition, as there seemed some apprehension lest the hospital's social work should be duplicated. Maternity cases were excluded. For this reason the number of cases for consideration was smaller than from the other hospitals, only thirty-five being offered. Of

these thirteen were not seen, leaving the following percentage compiled on a basis of the twenty-two cases seen:

Cases with Home Environment	Total Cases	Total Per cent
Favorable and adequate	1	4.5
Favorable with minor adjustments	10	45.5
Unfavorable but remediable	7	31.8
Unfavorable and not remediable	2	9.1
Acutely needing further hospital care	2	9.1
	22	100.0

One characteristic of this group as a whole was that the patients seemed to have achieved a definite idea of the hospital's plan for them and their repeated trips to the dispensary were playing an important part in their convalescence. The majority were looking upon the situation as a business proposition without imagination. The evident system and efficient working of the ward routine had impressed them and they were ready to do what was required. They seemed less susceptible to untoward surroundings at home because of the definite goal toward which they were working. Possibly this unanimity may have been more evident because of the smaller number, but it was too marked to escape notice.

The Collected Groups

Among the patients of all four groups were some who had been treated at two or more different hospitals for the same or different causes—the patient, not having mentioned this in giving her medical history at the hospital because she did not know, or "was not sure how to tell it," and thought "the next doctor would find out." In large families the hospital affiliation was widespread, several hospitals having been used by three or four members, and experience meetings when all talked at once brought out a variety of hospital lights and shades. This suggested the possibility of extending the scope of the Social Service Clearing House to include on its registry cards a note of any dispensary or hospital care which the patient had received—the technical details to be furnished by each medical agency as the occasion arose, as the patient is often unable to give an accurate account of past illness or surgical operations.

The very prevalent protest of the women patients against being kept in ignorance of the nature of their surgical operations deserves a word. The patient wants to know how she stands physically, even if she faces a serious handicap, and she can the better adjust herself to meet it if informed. The hospital service which shirks, evades, or refuses this after-treatment so necessary to the peace of mind and progress of convalescence has put the hardest part of the operation and its results on the patient, and has missed its best chance of rehabilitation.

Why bother at all if the game is not worth the candle—if the work is not to be carried through to completion and the seal set upon restored health

and higher spirit? If the patient is well enough to worry herself about her condition she is well enough to know what she has to worry about. She will then be more willing to put aside imaginings and prepare to recuperate in earnest.

Those who have had the fertile experience of a perfect convalescence have realized that there is much to be learned from contact with pain and weakness and returning strength. The convalescent patient should be helped to find these values, to lay aside a few worries and to take on a few new aspirations for the future. Inspiriting companionship may often be found in one's nearest neighbor with a wholesome philosophy to share.

In becoming acquainted with the convalescent in his own home we must let him state the difficulty of convalescence as he sees it, along with his own idea of rehabilitation before blocking the way with too many suggestions.

Often the patient must either resign himself to a reduced "health bank account" or remonstrate at untoward conditions; again, the uncertainty as to what his depleted strength is equal to, makes any definite undertaking precarious. This is no time for platitudes in words or actions. No "return to dispensary" slip will fill the need. Advice to "rest and take it easy" will not answer. Reinstatement into the type of life to which the patient is equal must be wisely planned and the very present helps of community life pressed into service, so that the thrill of ambition, the impetus to new life which rightfully belong to convalescence may not be entirely lost.

SUMMARY

Visits to two hundred patients discharged from the wards of Cleveland hospitals showed eighty-seven and one-half per cent. in home environment unfavorable for convalescence.

In two-thirds of these homes, conditions were remediable if adequate and adaptable Social Service could be supplied. This service is almost entirely lacking at present.

In one-third, conditions were not remediable, and care in a convalescent home was needed. With present resources it is impossible to meet this need. The hospital faces a choice of evils—it must either retain the patient, using a bed needed for a case of acute illness, or return the patient to a home unfitted to complete the cure.

Possible means by which the hospital may assist convalescence in the home:

1. Treatment and instruction in hospital towards securing the patient's confidence and cooperation—the instruction to include understanding of present illness and means of preventing recurrence.

2. Making with the patient a definite plan for his after-care and reinstatement into active life, and enlisting his best effort to carry out such a plan.

3. The function of the Social Service Clearing House might be broadened so as to include a record of dispensary and hospital treatment received by the patient, with names of institutions and dates. This record could be used by medical agencies concerned as occasion requires.

4. The function and value of the Convalescent Home, when suitable and available, should be explained to the patient as an opportunity.

5. Social Service (if a Convalescent Home is not available or desirable) should create the same essential values of convalescence in the patient's own home.

6. Teaching the patient while most receptive to suggestions—because of recent contact with the hospital technic of sanitation—how he may further the hospital's work to insure permanent good health. This would include the use of dispensary and other hospital resources, as well as of the family physician.

A patient thus successfuly involved becomes a valuable field agent who will set forth the work of the hospital in terms of appreciation which his neighborhood will not fail to understand.

A COMMUNITY PROGRAM FOR CONVALESCENT CARE

An institution is not the ideal place for convalescence from disease. The home, when conditions are satisfactory, is the ideal place. The possibilities of home convalescence are only beginning to be dealt with. In the preceding chapter home convalescence was touched upon in relation to the hospitals, with reference to planning the after-care for the patient, instructing him or his family properly at the time of discharge, using the dispensary to provide medical after-care, and social service. The last-named function served either by the social service department of the hospital, or by cooperating agencies such as the Visiting Nurse Association or the Associated Charities, is a necessity. It should further be borne in mind that the aid of social service is not called for merely in homes of poverty. Much work needs to be done in middle class homes by the Visiting Nurse Association or by a representative of the social service department to give the necessary instruction and friendly advice about the details of home management, diet, hygiene, etc., without which the family will usually not carry out the necessary routine outlined by the physician. Cooperation with the employer or the industrial physician, is not infrequently of great importance. The vast number of medical cases which are cared for in their homes by private physicians, and which convalesce at home need such advice no less than do hospital cases.

In a word, the broad problem of convalescence involves private medical practice, the hospital, the dispensary, the Visiting Nurse Association, and social service in many branches. Many individuals and many agencies must share in creating better opportunities for both home and institutional convalescence than now exist in Cleveland. An essential element to any real advance is an adequately maintained convalescent institution. Such an institution does much more than provide care for the particular patients who can be admitted to it. It would serve to stimulate medical study of convalescence, now a field much neglected, and would promote throughout the community, interest in the problem of convalescence which will add to the efficiency of all kinds of medical care in hospitals, dispensaries and in the home.

For an authoritative picture of the need for convalescent care in a community such as Cleveland, and a program for a central representative institution for convalescents, the Survey turned to Dr. Frederic Brush, Medical Director of the Burke Foundation at White Plains, New York, the leading institution in the United States for the efficient treatment and scientific study of convalescence. The following memorandum was prepared by Doctor Brush:

CONVALESCENT CARE

FOR AN AMERICAN CITY OF ONE MILLION POPULATION

By FREDERIC BRUSH, M. D.

The Need

There is a convalescent period in illness, with fairly distinct medical and social borders, and now recognized as a particularly favorable time for skilled

aid in rehabilitation. The patient's home is the desired, the cheapest, and best place for most convalescence, but institutional convalescence is needed for a certain percentage, in large cities.

Such an institution in its modern conception functions widely beyond mere recuperative rest—in prevention, education, refinement, and Americanization, occupational adjustment, vocational direction, encouragement, and all-round set-up for better living. It complements home care, and notably completes and fortifies social service. It shortens the hospital stay, with large increase of product, and with inspiration to the staff. It saves money directly (convalescent cost being but little over one-half hospital cost per day,) and makes large long term returns to the community in bettered personnel.

Numbers Needing Country Convalescence

Various estimates have been attempted based upon the number of hospital patients in the community, plus a small percentage from dispensaries, private physicians, employers, etc. These may be summarized into an ideal requirement of convalescent beds for ten per cent. of all hospital patients—varying greatly, of course, depending upon each city's conditions. To this should be added about one-fifth for dispensaries and other sources (as at present organized; but this ratio should be increased). Thus a city discharging 100,000 hospital patients yearly should provide institutional care for 12,000 convalescents.

Number of Beds and Apportionment of Patients

Assuming that the city in question presents the better living conditions, we may well take 5,000 hospital patients, plus 1,000 from other sources, as a planning basis. About twenty-one days proves to be the average stay in convalescent homes. The requirement for the 6,000 patients is accordingly 350 beds.

We may base an estimate upon the long and abundant experiences in our greater cities, and apportion them as follows:

1. The Main Institution, for adults—120 beds; men and women—ages, from fifteenth birthday upwards to old age, including 15 per cent. plus of heart disease, with standard surgical (with dressings), preventive and holding (chronic handicapped) convalescence.

2. Children's Home—100 beds, taking girls from 6 to 15 and boys from 6 to 10 years, receiving surgical dressing and orthopedic cases, and heart disease up to 20 per cent. of total, along with the standard lines as above outlined.

3. Boys' Place—30 beds, ages 10 to 15; disease classification as in the Children's Home (Very important but not to be large).

4. Mothers with infants and young children—30 beds, averaging 60 patients.

5. Special Heart Institution—40 beds, for the seriously ill, giving bed care at first, etc. Age and sex as in Number 2.

The Plants

New or expensive buildings are not essential. An old mansion, a large farmhouse with its many outbuildings, or a disused hotel adapt readily. Tents serve well at times; extensions are happily made; much equipment may be improvised. Five acres of land is minimum; the larger areas giving considerable advantages. These Homes might be conducted upon one large plot of 100 acres if the topography, etc., gave essential separation of patient's activities. A location well within 20 miles of the city's center should be chosen, if possible.

Costs

A per day capita cost of $1.75 may be expected, even under post-war conditions, giving $225,000.00 yearly operating expense for the 350 beds, as approximate. This includes transportation, and maintenance of a City Admission Office.

Selection of Patients, Follow-up, etc.

Careful selection of patients by one City Officer, given authority and support, is of first importance. This officer may be on part-time only. The necessary follow-up, including occupational and vocational direction, is usually well done by the city organization which sends patients, and the back-to-health-and-to-normal-life cycle is only thus completed.

Convalescent home planning, organization, and procedure are becoming fairly well standardized, with detailed information readily available.

Those of the Staff of the Survey who have been engaged in the local study of convalescent institutions and the convalescent problem can only add to Doctor Brush's statement some suggestions relating his program more in detail to present conditions and probable future development in Cleveland.

In most cities the convalescent problem, so far as it has been dealt with, has been taken up by bits and snatches. Here a group of kindly people have taken a large dwelling house and made it into a "convalescent home" for some twenty-five men; another committee of the charitable maintain a building donated by one of their number, in which sickly and tired mothers may recuperate after illness or operation; still another group has under its wing a small institution for children; and yet another a small "preventorium" for the pre-tuberculous child.

One of the great lessons which the Burke Foundation has taught is the greater efficiency gained through the use of a large institution instead of a number of little ones. The small independently managed convalescent home, accepting ten to fifty patients, secures with difficulty expert medical service of physicians who are particularly interested in the convalescent problem and scientific study of convalescent cases; it cannot possibly provide elaborate therapeutic equipment or a staff of special workers and teachers. In the large institution, therapeutic equipment, personnel and continuous service of a medical staff whose members are selected especially because they are interested in convalescence are all possible within reasonable limits of expense.

In a letter transmitting his outline, Doctor Brush remarks: "It may be well to bring to the attention of those becoming interested in this branch, some of the important points of this proposal: that preventative tuberculosis comes in under numbers 1, 2, and 3; convalescent orthopedics, bone diseases, etc., likewise in these three places; that cardiac children well enough for reconstructive treatment enter under numbers 2 and 3; that adolescents (the group most successfully dealt with and most neglected in convalescence) are especially well planned for. * * *

"Perhaps the most characteristic and radical part of my conclusions is the recommendation, based upon definite experience, for the care of many different classes and ages, etc., in one Institution (see numbers 1 and 2.)"

The recommendation to be made regarding the convalescent problem of Cleveland is that it be dealt with not by bits and snatches, but by one central and representative group of persons who will study the whole problem and, with a long range program in mind, will take each practical step as funds are made available. So far as institutions are concerned, there should be one, rather than many, or rather, as Doctor Brush's outline indicates, a group of related institutions managed as one.

At present Cleveland has:

Rainbow Hospital, with 85 beds, taking children between $2\frac{1}{2}$ and 14 years of age, mostly orthopedic cases.

The Children's Fresh Air Camp, with 60 beds (225 in summer), receiving weak, anaemic children and some convalescent mothers.

Holy Cross House, with a capacity of 50 beds, receiving crippled and invalid children (chronic rather than convalescent cases).

For adults a small number of chronic cases are held at City Hospital, but no convalescent cases are supposed to be there. At Warrensville Infirmary are numbers of chronic and incurable cases, but little provision for convalescents. In a few of the private institutions of the proprietary type convalescent cases are treated, but the number of beds available for such is very small.

Taken as a whole, institutional provision for convalescents in Cleveland is practically confined to children, and even for them is limited to certain types of cases. The main resources throughout the year are Rainbow Hospital, and in summer time, the Children's Fresh Air Camp.

The major need is that some one central and representative group should assume the responsibility of developing convalescent provisions which will be adequate for the needs of the city. It is recommended that the Trustees of Rainbow Hospital either assume this responsibility, or at least act as the agent through which some larger group might ultimately be organized. Rainbow Hospital now provides an excellent service to a limited range of patients, but appears to furnish a basis upon which a much more comprehensive and satisfactory development might be made.

With this in view, it is desirable that Rainbow Hospital should enlarge immediately the scope of its work. It should have no exclusive affiliation with any one hospital with respect to its medical staff or with respect to the reception of patients. It should aim to develop a staff which is especially interested in the scientific medical study of convalescence. It should at once undertake to receive a considerable group of cardiac cases from the children's services of the Cleveland hospitals, as well as convalescent orthopedic and surgical cases. It should institute studies of the convalescent problem in Cleveland, supplementing those made by the Survey, and through its members or representatives the Board should study notable developments in other cities, particularly the Burke Foundation, as a basis for the formulation of a program and of the definite steps which should be taken year by year towards its execution. Publication of these studies and reports of the case work with convalescents of various types are important phases of such a program, and are essential to the growth of appreciation of the convalescent problem by the medical profession and the public. Cooperative affiliation with related agencies, such as some of those above mentioned, would be desirable in the formulation and execution of any such program.

Provision of a convalescent institution for adults, should be made as soon as possible, as a part of this plan, either by Rainbow Hospital or by a group of persons organized in cooperation therewith.

The outline presented by Doctor Brush gives a program which for financial reasons alone cannot be realized in a day, yet nothing less than this should be accepted as worthy of a progressive city.

The cost of maintenance of a convalescent institution is about half that of a hospital receiving the same number of persons with acute diseases. A convalescent home is an institution which no city can afford to omit in providing for its sick. Its absence means burdens upon the hospitals, which involve undue expense, and burdens upon the community which are less easily traced, but which are no less real, being a financial drain upon the charitable public and a definite loss to wage earners and to employing interests.

When serious illness befalls, the care of the patient in home or hospital equires, as it were, an investment on the part of the community in order

that the sick man shall be restored to health and living efficiency. From the financial as well as from the humanitarian standpoint it is to the community's interest that this restoration shall be complete and shall be as prompt as possible. A period of stay in a hospital for acute diseases represents a part, often the most expensive part of the investment, but the subsequent period of convalescence, either at home or in an institution, requires a certain investment of time, skill, and money, also. Unless this subsidiary but important investment in convalescence is made, the value of the whole investment may be nil. It is difficult to put such an argument in financial terms of actual cases, but it should not be difficult to appreciate the tragedy and the waste of insufficient convalescence, and to strike the imagination of citizens of Cleveland who have the means, to support a program and develop an institution which shall be worthy of their city.

CHRONIC ILLNESS AND ITS CARE

Through the courtesy of the Visiting Nurse Association and the Division of Health, a list was secured by the Survey of all patients who were treated in their homes during the month of November, 1919, by the nurses of these organizations, who were regarded as chronic, incurable or convalescent cases. A list of 2,078 persons was furnished. In the absence of an opportunity to make intimate medical study of each case, it was not possible to draw a sharp line between the chronic and the convalescent, but only about ten per cent. were believed to be of the convalescent class. The remaining cases, some 1,800 in number, were chiefly people suffering from chronic disorders, living at home, but needing more or less regular nursing or medical attention.

A tabulation of these cases, classified by age and groups of diseases is given in the following table:

CHRONIC AND CONVALESCENT CASES UNDER NURSING CARE

Diagnoses	Cases
General	142
Respiratory (except tuberculosis)	63
Circulatory	37
Digestive	127
Nervous System	174
Mental	17
Total (not including tuberculosis)	560
Tuberculosis	1,518
Grand Total	2,078

	Adults	Children
Total cases (not including tuberculosis)	382	178
Tuberculosis	1,322	196
Grand Total	1,704	374

Opinions secured from the visiting nurses and checked by conferences with their supervisors, lead to the conclusion that such medical attention as was needed for these patients in their homes was generally secured by the family or on the initiative of the visiting nurse. The medical attention was either paid for or when necessary was obtained without charge from an interested physician or a district physician. Medical attention in many instances was or should have been secured through a dispensary, since many patients were able occasionally to go out of the house.

Each nurse stated her judgment regarding each patient, as to whether home care was practicable or whether institutional care was necessary. In 887, or 42.66 per cent. of the cases, institutional care was believed desirable. In the remaining 1,191 cases, or 57.33 per cent., it was believed that home care would be adequate. If we omit for a moment the tuberculosis cases, and consider the 560 patients with other diseases, we may estimate that less than half of these, or about 250, needed institutional care, and that the remaining number, or about 300, could be cared for in their homes.

In the special report of the Survey on tuberculosis, much attention is given to the shortage of sanatorium facilities, and the need for additional provision in order that at least all active cases of tuberculosis shall receive prompt and adequate institutional care.

This census of the chronic and convalescent cases in their homes is of course only a very imperfect picture. Only a fraction of the total number of cases would be known to any one agency, even to the visiting nurses, yet, taking these figures simply as they stand, it is apparent there were as many as two hundred persons, actually known to a responsible medical organization like the Visiting Nurse Association, who it is believed needed care in an institution for chronic patients, and who could not be properly attended to in their homes.

It would be highly desirable that at least once a year the Visiting Nurse Association should make a similar canvass and classification of its patients in order that the directors, and through them the whole public, shall be informed of these needs.

The problem of chronic illness must be clearly distinguished from that of convalescence. The convalescent patient is in the process of restoration to health. If institutional care is needed, the period of stay in a convalescent home is as a rule comparatively short. Two to four weeks after the usual acute illness or surgical operation is generally sufficient. The medical attention required is of quite a different nature from that needed in a case of chronic illness, where a definite disease process exists or there is a definite disturbance of bodily function which ought to receive close medical supervision and systematic treatment. Another important practical difference arises from the fact that the chronic case is usually a man or woman in middle or late life. To provide convalescent care for children is an important problem, whereas chronic illness among young persons is comparatively rare. Furthermore, cases of chronic disease which cannot be cared for at home are largely among the poor or those of very limited means, and with very unsatisfactory home conditions.

Considering all these points, it may be said that a very large proportion of the cases of chronic illness which require institutional care should be the responsibility of the city, rather than of a private agency. There is, indeed, room for a special hospital to care for the chronic and incurable which would devote particular attention to the interesting but as yet comparatively unstudied medical problems of these cases and which should provide for part-pay and pay patients, though having a certain number of low priced or free beds. The need for such an institution is at present met in Cleveland only by the inconsiderable provision of a few sanatoria or "homes" and hospitals of the proprietary type.

Eloquent testimony to the lack of present provision in Cleveland for the chronic case is derived from many of the leading hospitals of the city in which the Survey found large numbers of patients who had been in the hospitals a long period of time. On the two days, December 3, 1919, and January 15, 1920, on which a census was taken in the institutions of the Cleveland Hospital Council, a tabulation was made of the length of time the patients had been in the hospitals. For this tabulation, Warrensville Tuberculosis Sanatorium, Rainbow Hospital, St. Ann's Maternity Hospital, and Cleveland Maternity Hospital were omitted. The first two of these make special provision for long term cases and cannot be compared with a general hospital, while the latter two accept maternity cases only and for this reason should be omitted.

On December 3rd, there were 2,016 hospital patients in the group considered, and of these 243, or 12.5 per cent. had been in the hospital for over two months. On January 15th the number of cases in these hospitals was 2,029, and the number who had been in the hospital over two months was 286, giving again a proportion of 14.1 per cent.

The wide variation among the individual hospitals is shown in Table VIII, in the Appendix in which the figures for the two census days have been averaged for the sake of simplicity.

It is not necessarily true that a patient who is in a hospital over sixty days is a chronic case, because some patients with obscure diseases or who are slowly recovering from illness or operation, may properly remain in a hospital for several months, but the great bulk of these long-term patients are cases of chronic illness. Some of these patients are private cases and are paying their way, but the great majority do not pay even the cost of their care. Aside from the matter of payment, it is a serious waste of service in a hospital designed for acute diseases to have to care for chronic patients. It must also be remembered that the cost of giving adequate care for chronic patients in a suitable institution is only from one-half to two-thirds of the average cost of maintenance in a hospital for acute diseases.

From the figures secured in the hospitals and presented in the table, it is probable that 250 chronic cases are usually in Cleveland hospitals, in beds which are designed for acute cases and for which there is great demand.

The individual hospital is only in part to blame for these conditions. It is important to see just where the responsibility lies and what steps can be taken toward remedy. A few long term cases are retained in acute hospitals because they pay for the privilege, but these are not the majority. No hospital however should permit such patients to stay if there is demand, as there frequently is, for beds for acute cases. There is a much larger proportion of the long term cases who could be sent to their homes and suitably cared for therein if sufficient trouble were taken to make the necessary arrangements for medical supervision and for attention at home. Adequate home care of such chronic cases would require the hospital to have a social service department. An active social service department in a hospital would study out the home problems of the long term patients, finding just what would be necessary in the way of home provision, securing financial aid where this would be required and where the cost would be within reason, and enlisting the cooperation of the Visiting Nurse Association, the district physician, or other agencies.

When it is recognized that the cost of maintaining a chronic case in the bed of an acute hospital for a year is almost equivalent at present to the salary of a social worker during the year, and that a social worker would be able to work out the problems of a large number of such chronic patients so they could be cared for at home, it is seen that the present hospital policy is "penny wise and pound foolish." From the standpoint of individual hospitals, this statement may be controverted, since the hospital would have to maintain the bed anyway, and add the salary of the social worker in addition. But from the standpoint of the community and of the Welfare Federation as representing the community, it would be an actual saving to introduce a social worker and let the bed occupied by one or two chronic cases in the course of a year be occupied by twenty or more acute cases.

There are also a very large number of chronic patients who do not require the amount of care given in a hospital and who are not ill enough to be in bed all the time. These patients are suitable for treatment in a doctor's office, or, in the case of many, dispensary care is all that is necessary. The importance of dispensary care in chronic illness requires emphasis for the reason that a great many chronic patients are suffering from disorders which need very careful medical study to arrive at an accurate diagnosis, and therefore successful treatment; and such medical study often involves the services of one or more specialists, laboratory tests, the use of the X-Ray, etc. The expense of such diagnosis is beyond the resources of many people who can afford to pay a doctor and who usually have a family physician. The development of dispensary service in Cleveland is an important means of providing consultant and diagnostic aid. These patients, generally through their family

physician, could thus secure the special study and diagnosis necessary. An enormous amount of physical distress and suffering and of habitual living at fifty per cent. efficiency, exists because of the failure to study out conditions of a chronic nature, to arrive at a definite medical analysis of the character of the disorder and to outline a plan of treatment, hygiene and living conditions which will restore the patient to health or will maintain him at the highest physical grade possible for him. This class of ambulatory chronic patients represents a very large number, of which no census anywhere has yet been made.

After putting aside (1) the ambulatory chronic cases, (2) patients who are entirely able to pay for whatever care they need in an institution or elsewhere, (3) the patients who could be cared for in their homes with social service supervision, and (4) the tuberculosis cases whose needs are studied elsewhere, there remain those who definitely must receive care in a special institution for the chronic or the incurable, and who can pay little or nothing for what they receive.

To meet this need is the responsibility of the municipality. Warrensville Infirmary is the obvious institution which should play this part in behalf of the city.

The Infirmary occupies a well-constructed building, built in 1906, and placed in an excellent location. It operates a car to meet the Chagrin Falls street car line. About one hour is required to reach Warrenville from the Cleveland Public Square. Unfortunately, however, no other provision than street cars is made for transporting patients; there is no ambulance service. If a case of contagious disease develops at Warrenville, the patient must be taken to City Hospital in a truck.

The capacity of the Infirmary is approximately 900 beds. In March, 1920, there were 634 inmates. Of these 147 were insane. A further report stated that there were 46 cripples, 41 paralyzed, and 25 blind, who had been in the institution two or more years. Hardly more than half of the inmates in 1918 were American-born. There are no interpreters.

The personnel in charge of the institution consists of a Superintendent, non-resident, appointed by the Director of Public Welfare; a Medical Director (also in charge of the Workhouse and the Girls' Home), appointed by the Director of Public Welfare and responsible to the Superintendent; a Matron, appointed by the Mayor; and, at the time of the study, twenty-two attendants, not all trained—inmates being used where possible. The General Superintendent of the City Farms has some administrative control over the Infirmary.

From this account it is obvious that the Infirmary has not recently used its capacity, and that there has not been sufficient service to provide satisfactory care for even those who are there. On one day on which the institution was visited, there was but one attendant for three women's wards on three different floors, in which there were 120 patients, 40 of whom were semi-invalid. One nurse is assigned to make dressings, fifteen or twenty being the daily average. The Medical Director is so crowded with work, as he also has charge of the medical service at the Workhouse and the Girls' Home, that he can attend to only the most urgent needs. He is unable to follow up complaints or to answer letters which come to him complaining of the care of patients.

It was stated by the Outdoor Relief Department that a physical examination was part of the admission routine, the applicants being sent to district doctors or hospital dispensaries. There is no provision for a record of examination on the card, unless the diagnosis and condition should be mentioned in the investigator's report on the reverse of the card. No medical examination is made on entry to the institution, either for venereal diseases or for any other complaint; neither is a physical examination made afterwards.

It is decidedly unfortunate that in spite of the urgent need for more facilities for the care of chronic cases in Cleveland, only those patients who are physically able to care for themselves are considered suitable for Warrensville Infirmary. Bed-ridden cases and those which require more or less medical and nursing care appear to be regarded as undesirable.

With the present shortage of help and attendants this point of view on the part of the officials can readily be understood, but such a condition is not permanently tolerable. Here is a well located plant with 900 beds. In Cleveland are large numbers of chronic patients who are cared for in acute hospitals at undue expense, and with serious deprivation of service to the acutely sick. The city of Cleveland should meet its elementary responsibility in providing enough money to pay for medical, nursing and household service required to run Warrensville Infirmary to its capacity, so far as there is really demand for it.

In extenuation of the present policy it is fair to state that conditions during and since the war have made it difficult to secure sufficient personnel, yet the officials in charge do not appear to have made any such determined effort as the situation requires, to impress upon the city administration and also upon the public at large, the need of providing more funds for Warrensville, so that it could care for its inmates properly and so that it could be open to all the classes of patients who urgently require such care as this institution ought to render.

The institution provides practically no therapeutic facilities, such as massage, mechanical exercisers, electro-therapy or hydro-therapy. On the advice of a committee of the Cleveland Welfare Federation studying the

welfare of cripples, a trained occupational worker was employed, and in October, 1918, a workshop was opened for the men. Work for the women consists mainly of sewing and knitting. The provision of therapeutic facilities would be a great comfort to a large number of patients. Further development of the occupational work is highly desirable.

It is apparent that particularly under present conditions, the problem of securing sufficient nursing and attendant service is a difficult one, as is the related problem of household help. The distance of Warrensville from the city renders it less desirable from the standpoint of many employes than a more accessible institution. Higher wages will be generally necessary as a result, but even higher wages will not themselves usually prove a sufficient inducement, particularly when employment can be secured readily by people who are even moderately trained at any definite occupation. The living conditions must be made not only comfortable but pleasurable. The development of recreational facilities for those residing at Warrensville is a practical step which would be of much service and which would justify the necessary expenditure by the city. It would render possible the retention of a larger and certainly of a more stable staff, and would save more money than it would cost.

From the standpoint of the patients, entertainment and recreation are a very obvious measure of humanity, while from the standpoint of the attendants and the help, they are a practical measure of economical and efficient administration. The management of the Infirmary could doubtless secure considerable assistance from various Cleveland agencies interested in recreation.

A certain amount of music and other entertainment can be secured on special occasions with little or no expense. There is need for some person who will be definitely in charge of the recreation and social life of the institution, both for the patients and for the staff of nurses, attendants and help. Such a person would develop many resources within the personnel itself, and would organize social and recreational activities. With a little cooperation from the administration and some expenditure for equipment, music, etc., a great deal could be done.

Steps should be taken in making up the next annual budget for utilizing the Infirmary to a larger percentage of its capacity, in order to provide for the large number of persons in Cleveland who now need institutional care as chronic patients. There are at least two hundred such patients now occupying beds in acute hospitals in Cleveland, to the detriment of these hospitals' service, while really acute cases must moreover be turned away for lack of beds. If Warrensville can be provided with sufficient staff to make care satisfactory for the inmates, it would undoubtedly be possible to keep it full up to nearly if not quite all its capacity of nine hundred beds.

To sum up the situation in Cleveland regarding chronic illness and its care, it may be stated that:

1. There are at present at all times several hundred patients in the hospitals of Cleveland, designed for acute cases, who are chronic cases and should not be in these hospitals at all.

2. As a result, hospital service is rendered less available, and the acutely sick must often be denied needed care because beds are taken.

3. There are very large numbers of ambulatory chronic cases who require study by specialists, the aid of laboratories and of other diagnostic apparatus in order that they may receive sufficient medical study to be properly treated. The shortage of dispensary and consultant service for the physicians of Cleveland at present renders it impracticable for many of these patients to secure what they need.

4. The lack of a sufficient number of privately supported institutions furnishing a high grade of care for chronic cases who can pay, forces the acute hospitals to retain a number of such patients and leaves the remainder to be inadequately cared for at home or in the few small proprietary institutions who seek such work. There is undoubtedly place for a well-managed institution for chronics, which could be largely or wholly self-supporting.

5. Adequate social service departments would enable a considerable number of chronic cases now in acute hospitals to be cared for properly in their homes. A definite economy to the community would result. This is an additional reason for the increase of hospital social service in Cleveland, the need for which is more fully discussed in the next chapter.

6. Provision for those chronically ill who cannot be cared for at home and who cannot pay their way in an institution, is a primary responsibility of the municipaltiy. Warrensville Infirmary has the space and needs the additional personnel with which to meet this responsibility. There should be unremitting effort by the Department of Public Welfare until funds are provided for this purpose. Such chronic cases should not be retained in any considerable numbers at City Hospital, whereas as many as 300 beds could well be used at Warrensville, not including in this number those who are crippled or merely infirm from age.

7. The large number of tuberculosis patients found in their homes by the Survey emphasizes the need, brought out in the special report on tuberculosis, for increase in sanatorium provision.

SOCIAL SERVICE IN HOSPITALS AND DISPENSARIES

It is only fourteen years since the first hospital social service department in the United States was established in Boston. Today over three hundred hospitals have taken on this new and important adjunct to their medical service. It is curious that a community so advanced as is Cleveland in many respects should have made only a slight development in the social service activities of its hospitals and dispensaries.

Three hospitals in Cleveland have organized social service departments. Four other institutions have each one person who is devoting some attention to social and financial relationships connected with patients. The Lakeside Hospital Social Service Department has been in existence seven years, that at Mt. Sinai three years, and that at St. Vincent's Charity Hospital one year. Each of these social service departments began with one worker. Lakeside had six workers at the beginning of 1920; Mt. Sinai four and Charity five. These departments have developed independently and there has been no uniformity in policy.

At Lakeside, the social service department appears to be an outgrowth of the visiting nursing service. For a number of years its activities have been almost entirely confined to the dispensary, and its head worker was practically responsible for admission of patients and for many details of dispensary administration. It is unfortunate that for a number of years this department has maintained a policy of medical secrecy which has prevented its meeting the needs of agencies such as the Associated Charities or making a contribution to the community health problem. To furnish to a charitable agency information regarding the medical condition and the health needs of patients in whom the agency is interested is part of the responsibility of a hospital or dispensary. To effectuate this relationship between the hospital and the outside non-medical charity is part of the duty of the social service department. Lack of records in the social service department at Lakeside has rendered it impossible to study the social conditions which cause disease or which render its successful treatment impracticable unless they are altered. Although Lakeside Dispensary is a teaching clinic of Western Reserve University Medical School, the social work is not so connected with the organization as to bring the medical students in contact with it and enable them to learn something of the relationship between the medical and social problems. This has been done in a number of other leading medical schools, notably in that of Indiana University.

At Mt. Sinai Hospital, the social service department was organized as a definite part of the dispensary, and has been much more intimately related to the medical service on the one side, and to the social and charitable agencies on the other. As at Lakeside, a considerable part of the time of the social service staff has been spent in assisting in the administration of the dispensary. As at Lakeside, a lack of clerical assistance has made adequate records impracticable, so that much of the research value of the work has been lost.

The recently developed department at St. Vincent's Hospital is like the others, largely concerned with the dispensary rather than with the hospital cases. Lack of clearly defined policy other than to do kindly and friendly things for patients is apparent here as often elsewhere in this new branch of service.

In the prenatal clinic at St. Luke's Hospital a nurse spends half her time admitting dispensary patients and in making financial investigations for the hospital, and this is called social service.

At the Babies' Dispensary a graduate nurse, called a "social service nurse," is responsible for the admitting of new patients, and classifies them according to their ability to pay the various grades of fees in this institution—admitting them or referring them elsewhere according to her judgment.

At City Hospital there has been a single worker, who without any definite policy or guidance, has endeavored to mitigate personal or other problems for those few patients she could reach among the thousands passing through that institution yearly.

At Rainbow Hospital is a "social service nurse," who does follow-up work for the children who are discharged.

In addition to the activities of these seven institutions, the Association for the Crippled and Disabled maintains a social service department of a distinctive and efficient sort. While not properly speaking a hospital social service department, its work is of very similar character. A description and evaluation of this will be found in the portion of Part II. which deals with the care of cripples.

The most striking fact about hospital and dispensary social service in Cleveland is the lack of any definite conception of the policy which a social service department should pursue and of its relationship to the organization of the institution in which it works. In no department does there appear to be a clear recognition that the prime basis of social service in a hospital or dispensary is the assistance of medical treatment. Social service is not or rather should not be in a medical institution for the sake of being kind to patients, or for the sake of finding out what patients can pay the hospital fees, or for the sake of helping to run the dispensary.

Kindness is a general function of a hospital organization—not an attribute of social service in particular. The fixing of fees or finding out whether patients can pay is an administrative function, to be performed by a financial investigator. It is a serious interference to any really constructive social service to patients if the worker who is supposed to render such service is placed in the position of an inquisitor into the details of personal income.

Helping to admit patients to a hospital or dispensary or to administer a dispensary is a useful and necessary service which social workers have often been called upon to do since no other trained persons have been available, particularly in a dispensary. Social workers have been rendering such administrative assistance in several dispensaries of Cleveland as in other cities, and have been of substantial value to their institution and to the patients by doing so. It is quite true that assistance in many phases of administrative work in hospitals and dispensaries falls naturally to social service. When these pieces of administration involve personal dealings with patients (as in admissions or in the management of clinics) the training and practical experience of the social worker is of distinct value.

Physicians in a hospital do various things which a layman might do, such as making records or assisting in administration; so also nurses do many things for which their special training as nurses is not a pre-requisite, but the essential reason which brings a doctor to a hospital is the activity which he alone is trained to perform—medical diagnosis and treatment. The reason why nurses are in hospitals is because there are certain duties which only trained nurses can perform—the bodily care of patients and assistance of physicians during operations and in therapy. The distinctive function of social service which brings the social worker in the hospital and dispensary is the contribution which she can make to medical treatment, assisting the physician in securing those facts about the patient's personality and environment which will bear upon the cause and characteristics of his disease, and aiding the physician in planning and carrying out the details of treatment which under the conditions of the patient's character, family, and finances, are necessary to secure the best results.

In the hospitals and dispensaries of Cleveland, social service has been largely introduced as a measure of kindness and as a helpful agent in administration. There has nowhere been recognition of any definite policy or of the essential relationships between hospital social service and medical treatment.

> A trained social worker is one who has learned to make critical but sympathetic judgments of the human problems usually presented, and who has also learned how these can be dealt with effectively in practice. As an example of the questions which face medical and social workers and which need trained social judgment for their answer, we may cite:
>
> Shall material relief be obtained for a family for the three or four months during which the father will be in an institution because of sickness, or shall the five children and mother be placed in four different homes of willing relatives during that period—a course to which the mother strenuously objects?
>
> Shall a delicate child with kind-hearted but quarrelsome and uneducated parents, be placed in a country home for six months; or shall an attempt be made, through the parents' love for the child, to reconstitute family life sufficiently to enable the girl to get well at home?

> Shall an unmarried pregnant girl of 21 be urged to marry the father of her child if the man is willing, although the girl has lost her confidence in him, or shall she be helped to fight her battle of life alone?*

The answer to such questions requires in the first instance, careful study by the social worker of the patient's personality and family circumstances, reporting to the physician and deciding in conjunction with him the proper course to pursue, having both medical and social facts in mind.

There is very little indication from the studies made of the work of the social service departments in Cleveland that this type of analysis is practised in its definite relations to the medical problem of each case. The character of the disease is of vital influence in determining what treatment is necessary, but how the treatment shall be applied depends in a large measure upon the patient's personality and environment.

In addition to the study and analysis of the case necessary to form judgment as to the social causes of the disease and of the conditions which will affect its treatment, the social worker in the hospital or dispensary must also endeavor to help in the accomplishment of the treatment, as by finding a job for a man with a damaged heart, getting food or money for an undernourished family with three sickly children, or by securing a vacation, a friendly visitor, or the help of a relative so that a woman will consent to have an operation in the hospital, knowing that her children are properly cared for meanwhile. In these types of practical service, where the problem is rather obvious, persistence and resourcefulness are often shown among the cases studied in the Cleveland social service departments, but because of the combination of lack of definite policy and of pressure of administrative work, there has been little real study of cases so as to bring out relationships between disease and social conditions, thus enabling a really definite and well rounded plan to be made for combined medical and social treatment.

It must be apparent that in many cases where the personality of patients or family difficulties or lack of funds are involved, medical treatment is largely or wholly wasted unless adequate social service goes with it. The primary and fundamental recommendation therefore for the social service departments of Cleveland is a definite aim—a clear-cut policy.

The need for sufficient medical social service in the Cleveland City Hospital is the outstanding requirement when individual institutions are considered. In a large municipal institution of this sort the great majority of the patients come from home conditions which render convalescence difficult (as has been shown in the section on "The Convalescent and the Hospital") or the hospital's care is of greatly diminished value in restoring the individual or family to health unless something more is done than simply to provide the surgical operation or bed care during an acute illness.

* Davis & Warner, "Dispensaries." 1918. Page 114.

Waste of human energy, increase of human suffering, and fruitless expenditure of public funds goes on at any large municipal hospital without social service—the institution can merely render medical attention during the acute stage of an individual's illness, and passes by related conditions in the man or in his home or his occupation.

Re-occurrence of illness, re-admission to the hospital, lowered efficiency of the patient and family, further illness, and family deterioration, make a vicious circle which the most skilled surgeon and finest diagnostic equipment cannot break alone.

In New York, Bellevue Hospital, with 1,300 beds, has a social service department with 30 workers. In Boston, the City Hospital, an institution only a little larger than the City Hospital of Cleveland, and much smaller than the enlarged City Hospital which Cleveland will soon possess, has 17 social workers. At the Cook County Hospital, Chicago, there is a social service department with 8 workers, and in the social service department of Cincinnati General Hospital, there are 4 workers.

The larger the institution, moreover, the greater is the need that the head worker be a person of unusual personality and previous definite experience in hospital social service. The Cleveland City Hospital needs an adequate social service department with a strong, well-trained woman at its head. She should be responsible to the superintendent of the hospital, but there should be a social service advisory committee appointed by the Director of Public Welfare (or by the board of trustees if such a board is formed for the City Hospital). The duties of such social service committees are touched upon later in this chapter. This committee would be of particular importance to City Hospital during the first years of development of adequate social service there.

It may be mentioned that some years ago a social service department was started in the Boston City Hospital on the initiative of a number of private citizens, including some of those closely associated with the institution by medical interests. Private funds supported the original staff, but the city soon entered and paid a share as the department enlarged. While at present some of the staff of workers are still supported by private funds, the outcome will undoubtedly be complete municipal support. At no time, however, has there been any question of division of responsibility for immediate control by the hospital. In a municipality with the active civic spirit of Cleveland such initial sharing of the burden of hospital social service by private funds ought not to be necessary; but it is not at all undesirable.

The Welfare Federation has certain special reasons for supporting social service in hospitals and dispensaries. A very large proportion of poverty is caused by sickness or is accompanied by sickness, making it useless to attempt to restore the family to self-support until the illness has been successfully treated. Studies in a number of cities indicate that sickness is one of the conditions accompanying poverty in from 60 to 80 per cent. of the families known to such an agency as an Associated Charities. Since the members of such families obviously cannot afford a private doctor, it may be said that

the hospital and dispensary must be their family physician. The charitable agency must look to the hospital and dispensary for medical diagnosis, advice and treatment, and the agency requires the constant cooperation of the hospital and dispensary. Without the social service department this cooperation generally proceeds with halting steps. The social service department is the link between the highly organized, specialized medical institution and the community agency which deals with the family in its home. Without such a link, much money and much time are wasted by these agencies. Thus it is not only in behalf of the intrinsic service to the patients of hospitals and dispensaries that social service has a claim to support, but also because the work of other charitable agencies which are members of the Welfare Federation will be very substantially assisted thereby.

The special need of hospital social service in connection with the convalescent and the chronic case has been brought out in the preceding chapters.

The section dealing with the plan of hospital organization includes a brief statement concerning social service. A social service department should be part of the hospital organization, not maintained by any outside agency. Social service needs to work intimately within the hospital and hence to be an integral part of its administration. The head worker of the social service department should, like the heads of other departments, be responsible to the superintendent, but it is advisable, particularly during the formative stages of social service, to have a social service committee, including a few members of the board of trustees, one or more members of the medical staff, the superintendent ex-officio and other persons who are familiar with general philanthropic work and whose advice regarding the policy and problems of the department will be of value. Such a committee should be advisory, like others suggested in the scheme of organization.

The personality of the head worker and the quality of her training and experience are of vital importance to a social service department. There has been in Cleveland, as in a few other cities, much discussion as to the training necessary for a hospital social worker, and in particular of her relation to nursing. A nurse's training does not provide one of the essential elements for a hospital social worker, nor can this be gained by a brief period of observation of social service or by a two or three months' "course." Not less than one year's study of social work and an additional year of practical experience under educational supervision is necessary to render any person a competent worker in so difficult and complex a field as this. The training of a nurse provides important knowledge of medical matters and a familiarity with the point of view of physicians and patients, and with the conduct and administration of hospitals and dispensaries. Actual experience in many social service departments throughout the country has proved that, as a matter of fact, some successful workers are nurses and that some of them are not nurses, and that to debate as to whether a hospital social service worker must be a nurse or must not be a nurse is merely a waste of time. Personality implying effectiveness in dealing with people, a certain degree of administrative and executive ability, and a definite training in the analysis of social problems and familiarity with the methods of dealing with them,

are essential elements, as well as certain subject-matter concerning particular diseases or medical problems to be dealt with. During the present formative period of social service, too much care cannot be taken in selecting the right quality of head worker, and then leaving it largely to her to nominate and appoint her assistants.

Social service in the hospital and dispensary must be viewed primarily as an adjunct of medical treatment. It is usually desirable that social service shall assist in various administrative activities, as in connection with the admission of hospital patients, the admissions to the dispensary or the management of dispensary clinics.

It is not desirable, however, that a member of the social service department should be used as the financial investigator of the hospital. The utilization of social workers at the admission desk of a dispensary is desirable, but the financial grading of patients should not be her primary responsibility, nor should financial grading be of such rigidity as exists at the Babies' Dispensary, or existed until recently, at Mount Sinai. Such rigid grading tends to develop arbitrary standards of dealing with patients, on an entirely superficial basis, establishing a wrong relationship with a patient by emphasizing his financial rather than his physical need. It is well that Mount Sinai has discarded the custom.

It may be added that it is not desirable to have any person kept continuously at the desk admitting patients to hospital or dispensary without being assigned a portion of her time to other phases of social service, particularly the study of families in their homes. The admission of patients requires a series of "snap judgments," based necessarily on slight information. In order to keep any person from becoming "routinized," losing freshness and flexibility, the effect of making necessarily hasty judgments in the admission of patients must be counteracted by giving the worker some, even if only a small amount, of time for intensive observation and service with a few patients in their homes.

In a dispensary the social worker can be of value not only at the admission desk, but in various phases of dispensary administration, notably in the detailed executive management of clinics. The routine of the clinic needs adaptation to the needs of each patient. The doctors' time should not be taken up with executive detail but should be given to medical work. The social worker, as clinic executive, is a great aid alike to physician and patient.

The Social Service Clearing House supported by the Associated Charities provides (a) registration of families known to charitable agencies. By means of this there is at the office of the Clearing House a list of families or "cases" known to any agency using the Clearing House, and with the name of each case or family is a list of the agencies which have been interested in this case. The Clearing House also provides for (b) answering inquiries from agencies about families and telling them whether any other charitable agencies are interested in the family, and if so, what agencies. By this means a charit-

able agency may find out the names of those who have previously known a family and then, by calling these agencies, learn what has been or is being done for the family.

The Clearing House is very largely used by hospitals and dispensaries of Cleveland. During 1919 a total of 39,569 inquiries were made, and of this total of 25,966 or 43 per cent. were from medical agencies, chiefly dispensaries. Such registration takes place largely through the social service departments of the dispensaries and through the nurses in the health centers.

Registration of dispensary cases in the Social Service Clearing House, however, is not accompanied by full use of the information thus secured. When the dispensary registers a case it learns automatically by the reply slip, sent from the Clearing House, the names of the agencies who have formerly known the family. If the social service department of the dispensary does nothing further the time spent in registering the family is practically wasted. It is found that in a large number of cases no use of the information secured from the Clearing House is made.

The Social Service Clearing House is a most important means of promoting team work among agencies and of avoiding overlapping in dealing with families. Its use should be increased in every way, but it is a question how far mere registration without making use of the information is worth while.

It is recommended that a conference be held of representatives of the Associated Charities maintaining the Clearing House and of a number of representatives from medical agencies, particularly the large dispensaries and health centers, and that the following questions of policy be discussed and, if possible, decided.

1. Shall it be the policy of the agency to register all cases, or only cases in which it is likely that they will make use of the information secured from the Clearing House?

2. If the latter, decision should be reached by each agency as to what types of cases, classified in medical or in other ways, they will register, and the Clearing House should be informed of this policy and of changes from time to time.

It is desirable that as large a number of cases be registered as possible, but mere waste of effort in futile registration should be avoided. It is necessary to draw the line at the right point, given a certain sized social service and clerical staff in each medical organization.

It is not deemed advisable that a routine social history be taken of every patient, as is done in some clinics, notably at Mount Sinai. Many facts of value are found through conference between social worker and patient, but unless there are enough social workers to take up these cases and deal with the needs found, the time taken in getting a thorough social history is largely

or wholly wasted in many instances. Unless a dispensary has a very unusual number of social workers, such as no dispensary in Cleveland has at the present time or is likely to have in the near future, it is advisable that detailed social histories be taken only on selected cases, the social worker at the admission desk or in the clinic determining (on necessarily brief judgment) which cases shall be selected.

Social service departments have generally suffered from lack of sufficient clerical assistance to keep adequate records which are required in social service as in medicine, for good work. Furthermore, it is not economical to take a large part of the time of a social worker for clerical tasks.

Finally, it is urged that a definite portion of the time of the head social worker or of one of her best assistants be devoted to the constant study of the social problems of the hospital and dispensary, and their interpretation to the staff and the administrative authorities of the institution. Periodical studies of the social problems of selected groups of patients are practicable even in a small social service department, if the groups selected are small, but judiciously chosen so as to be medically and otherwise significant. Such studies and reports on the social problems of these patients outline to the staff and the administration the social conditions influencing some of the chief diseases treated in the hospital and dispensary. Only in that way can the policy of the social service department be expected to grow, and the hospital and dispensary steadily advance in a broad policy of prevention as well as cure, and of widening service to the community.

AMBULANCE SERVICE

To understand what the ambulance system of Cleveland ought to be it is necessary first to outline the present situation.

There are three different agencies in Cleveland which may be called upon for ambulance service. The Police Department has "Police Emergency" cars, used for the sick or for the law-breaker, as the need may be. City Hospital owns three ambulances (two Atlas cars and one Ford) but has only one in commission.* The Survey was informed that each of the local undertakers, of which there are over 100, has one or more "combination-wagons" (combination "dead-wagon" and invalid carriage).

From January to November, 1919, the police answered a total of 3,290 ambulance calls. The City Hospital ambulance was out of repair for five months of 1919, but during the other seven months made 937 calls. The number of calls answered by the undertakers could not be estimated.

In contrast with these provisions may be cited the provisions found in several other leading cities. In New York City the ten public hospitals operate 31 ambulances, and in addition, 35 private hospitals provide a total of 70 ambulances. The City Hospital in Providence, Rhode Island, has three ambulances. In Jersey City the City Hospital has six ambulances. In Philadelphia about 35 private hospitals own ambulances and their services for emergency work are recognized by an annual appropriation of $300 to each hospital from the city.

The distribution of ambulances has an important bearing upon their availability and promptness in answering calls. A police ambulance is stationed at each of the fifteen police precinct stations of Cleveland except at Precincts 4, 10 and 15. The City Hospital ambulance is expected to serve the entire city, and the service of the ambulances provided by the undertakers is not districted. Calls for the Police Emergency are supposed always to be sent to the Police Information Bureau, and then to be relayed to the nearest precinct station, although they may be received directly at the precinct station itself. If the emergency patrol at the nearest precinct station is not available, the call is transferred to another district office. So far as could be ascertained, there is nothing to prevent a person from calling the police emergency, City Hospital ambulance and an undertaker's car, for the same emergency case.

In a matter where a few minutes time may be of such vital significance, the promptness with which ambulance calls are answered is of decided importance. The consensus of local opinion seemed to be that the police emergency cars were prompt in arriving, but there was universal criticism of the utter unreliability of the City Hospital ambulance in answering calls. Delays of many hours often occur and it has not been at all unusual for the ambulance not to arrive until the next day after the call was sent in. One of

* Note—It is understood that a new ambulance has recently been purchased for City Hospital.

the hospitals reported a case of pneumonia, for which the City Hospital was asked to send an ambulance on the 18th of the month. The ambulance was promised for the 20th but never came at all. In the case of contagious diseases, which can only be received at City Hospital, and for which the City Hospital ambulance is the only logical and suitable means of transportation available, such a delay means unnecessary exposure of other persons, especially dangerous in the crowded homes and lodging houses from which the City Hospital patients are apt to come. It is our opinion that at least two more ambulances should be provided for transporting contagious cases, so that all these cases may be cared for by the City Hospital's own ambulances. It is also felt that twenty-four hour service should be provided by the City Hospital for contagious cases. With the transportation of contagious patients concentrated under the control of City Hospital, the hazard of poorly disinfected ambulances, such as at present exists, could be obviated.

Inasmuch as a patient for whom an ambulance is called is often seriously ill or injured, ambulance service must mean more than mere transportation from one place to another. An injured man may have to be carried from his house to the ambulance. A person hurt in a street accident may need some form of first aid in order to save his life. A case of acute illness needs to be made comfortable for the ride to the hospital, and in winter needs to be sheltered adequately from the cold. In case of contagious disease, the ambulance must be disinfected in order to protect the next patient using it.

These requisites of efficient ambulance service are met, when met at all in Cleveland, in varying degrees.

The Police Emergency cars carry the driver and one other policeman. The City Hospital ambulance sends someone with the driver, if the patient must be carried. One undertaking firm which cares for many of this class of cases sends only the driver of the car.

Training of the ambulance crews of the police force in first aid and the proper care of patients on their way to the hospital, has not been so complete and adequate as is desirable. A lecture on first aid is given by a physician at each district, and instruction is given in the use of the pulmotor. A few years ago lectures and demonstrations were given by a representative of the Life Saving Corps of the Red Cross. Comment has come to the Survey of the kindness of the police who serve with the ambulances, but more than kindness is needed to give first aid treatment in case of sun-stroke or suffocation. Skill and definite training are necessary. The policemen assigned to ambulance service should be required to pass a thorough course in first aid, consisting of both theory and practice. The provision of an adequate emergency kit for each ambulance would seem imperative, yet the police patrols are provided with only tourniquets, rubber gloves and handcuffs, and the City Hospital ambulance had no first aid equipment at all. This absence of first aid equipment is not excusable, and should be remedied without delay.

At present there is no continuous assignment of members of the police force to the ambulance service, so that a man with proficiency gained by experience (in lieu of training) may be replaced by one to whom the simplest matters of emergency treatment are unknown.

No matter what the ailment of the patient may be, the ride to the hospital needs to be made as comfortable as possible. The following incident, similar to many which have come to the attention of the Survey, was reported from the personal observation of a member of the Survey staff, on one day during the winter. The Police Emergency was drawn up in front of a store on lower Euclid Avenue, and a shivering, pallid woman in a semi-conscious state was carried out and placed on the hard, unpillowed leather shelf of the ambulance. There was no blanket to protect the woman from the cold northeast wind, and her husband covered her with his coat.

The type of ambulance used by the police department is uncovered at the end and the cars are very unsuitable for cases of serious illness, especially for patients with respiratory disease. The City Hospital ambulance, however, is a closed car with a stretcher.

The Animal Protective League operates two ambulance trucks for the transportation of dogs, and was at the time of the study having another one made. Their ambulances are fitted with adjustable cages. The interiors of the cars are painted, and the cars are washed out with hot water to keep them in a clean and sanitary condition. In winter the exterior wire sides are covered with regulation side curtains. The humane care of dogs is a matter which should be of concern to every person, but it is certainly only reasonable to insist that at least the same degree of humane care be rendered to human patients who through illness or accident are forced to use an ambulance.

The matter of disinfecting an ambulance which has carried a patient suffering from contagious disease, is one of importance. Some provision is made for disinfecting the police emergency cars by formaldehyde spray, but conference with the policemen in charge of these cars convinced the investigator that very little real disinfection was done. Disinfection of the City Hospital ambulance by wiping out with cloths moistened in creolin solution, and change of pillow case and blankets, is carried out on return from transporting a case of contagious disease only when the case next to be called for is one of a different contagious disease. From numerous complaints by physicians it would seem that undertakers often fail to make any provision for disinfection, although no data on this matter were obtained.

One thing which has impressed itself most forcibly upon the Survey staff is the general unwillingness of the dependent sick to use the Police Emergancy ambulance. Well-to-do patients can of course, afford to pay the fee charged for the use of undertakers' cars. Innumerable cases were found however, where patients who could ill afford the five or ten dollars, summoned the private ambulance rather than endure the stigma of riding in the police emergency. It must be remembered that to all practical appearances there

is no distinction between the sick man in the police emergency and the man who has been engaged in a street fight or some less commendable pursuit. Natural pride and self-respect resent such a method of transportation in case of sickness or injury, and this feeling of resentment is justifiable. Certainly a more dignified and considerate method of conveying a patient to the hospital needs to be provided. On the other hand, it seems just as unfortunate that an undertaker's wagon should be used for carrying patients.

No ambulance service is provided for taking patients to Warrensville Infirmary or, in case a contagious disease develops there, for removing the patient to City Hospital. In the latter case a delivery truck is used, an arrangement hardly to the credit of the city of Cleveland.

It is believed by the Survey that at least the Cleveland hospitals maintaining over 200 beds should provide their own ambulances, and that the smaller hospitals might combine in some manner under the Hospital Council. In order to maintain such a system of ambulance service in a satisfactory manner, it is necessary to have some central organization. In Cleveland, so long as the present police emergency ambulances will doubtless remain in use for some time, even though individual hospital ambulances are provided, it would doubtless be best to retain the present central call bureau under the jurisdiction of the police department, assigning an emergency district to each hospital providing such service. The method of handling ambulance calls used in New York City may be taken as the basis of a system for Cleveland. In New York the city is districted for emergency ambulance service and there is a central bureau to which all emergency calls are made. This central bureau is at all times informed of the movements of each ambulance, whether it has gone for a patient, or whether it is available for use on a call. When an emergency call is received it is relayed to the proper district office. With a little modification the present central call bureau of the Cleveland Police Department could be adapted for the use of an efficient city-wide ambulance system.

The following recommendations are considered essential to the improvement of the ambulance service of Cleveland:

RECOMMENDATIONS

The police patrol wagons should be replaced by ambulances for use in emergency work, and the use of police patrol wagons for ambulance transportation should be discontinued as rapidly as possible.

Each ambulance should be provided with a stretcher, blankets and ordinary first aid equipment, including a Thomas splint.

At least four such cars should be provided and stationed in appropriate sections of the city.

The policemen assigned to ambulance service should be required to pass a thorough course in first aid, consisting of both theory and practice. This instruction should be

under the direction of the Division of Health. Assignment to the ambulance branch of the police service should be continuous.

At least two more ambulances should be provided at the City Hospital to be used for transportation of contagious cases from all parts of the city to the City Hospital, and for transferring cases to and from Warrensville Infirmary and Sanatorium.

Twenty-four hour service should be provided by the City Hospital for the transportation of contagious cases.

Hospitals of over 200 beds should provide their own ambulance service, smaller hospitals combining with one another under the Hospital Council to provide such service. The larger hospitals also might find it advantageous to come into some such joint scheme.

As ambulance service is provided by individual hospitals, an agreement should be reached with the Chief of Police by which an emergency district would be assigned to each hospital providing such service.

The existing centralized system of calling for ambulances at the Police Information Bureau should be continued for all emergency work.

The hospitals and public health agencies should discontinue the use of undertakers' invalid carriages for ambulance service.

V. Hospital and Dispensary Planning

COMMUNITY PLANNING

From the standpoint of the community, hospitals and dispensaries in Cleveland have been planted, rather than planned—planted each by itself instead of being planned as part of a community scheme for organized medical service.

The hospitals thus planted have grown, but have not grown fast enough to keep pace with the development of the city. This is even more true of the dispensaries, the starved children of the hospitals. The outstanding, almost tragic, fact in the situation of Cleveland is the shortage of 1,500 beds below present community needs, and the deficiency in dispensary service, which at present is not more than one-third of the needed amount.

These major needs are a challenge to the courage and resources of a progressive, self-confident city such as Cleveland. The passage of the City Hospital Bond Issue during the spring of 1920 for $3,500,000 gives assurance that when the necessary steps of making plans, selling bonds and putting up buildings have been taken, at least one-third, or possibly half, of the needed 1,500 beds will be provided.

It was originally expected that the $3,500,000 would be sufficient to construct 900 beds and a dispensary, tearing down the present psychopathic building of 200 beds, which is unfit for hospital use; and thus making a net addition of 700 beds. The City Hospital would then have practically 1,500 beds, and it should have this number as soon as possible. Since the figure $3,500,000 was decided upon by the authorities, building costs have continued to rise, and (while the future course of prices cannot safely be predicted) it is probable that the sum will be insufficient to build any such number as 900 beds, besides a dispensary and necessary enlargements or improvements in nurses' home, power plant, kitchen, etc. The present city administration should proceed as rapidly as possible with plans and construction, making the $3,500,000 go as far as it can, and all public officials and private persons who have the hospital interest of the city at heart should continue their efforts until the City Hospital has reached the needed size.

Privately supported hospitals must expect to provide 750 to 900 beds of the needed 1,500, as soon as possible, and also the dispensaries, as outlined in the discussion of that subject. An expenditure of probably $12,000,000 for buildings must be faced by the people of greater Cleveland during the next few years.* This figure does not include such special provisions for research and medical teaching as may be provided in connection with the University Hospital. Of the $12,000,000 it may be expected that two-thirds, or a little less, will have to be provided by private gifts, and about one-third, or somewhat more, by the municipality.

*This sum includes $3,500,000 bond issue. At the time of concluding the Survey the bonds had been authorized but not marketed.

In one of the striking financial "campaigns" of recent years, the Jewish Community of New York City, with a population only slightly more than the total population of Greater Cleveland, raised more than $7,000,000 for building funds for its various institutions. Cleveland has let its population grow faster than it has permitted its hospitals to grow. Atonement for the neglect of yesterday can only be made by dipping more deeply into the pocket today. Delay means only the incurring of still heavier future obligations.

It is greatly to be desired that in securing these building funds Cleveland shall pursue the policy already so finely established through the Welfare Federation in raising annual expenses. Joint campaigns for hospital building funds are the desirable method. Otherwise Cleveland will be weary with one hospital "campaign" following another, with the almost inevitable result that those which happen to have been unable to make campaigns first will suffer, and the response will be influenced more largely by chance than by relative need or merit. What is of even more importance is that balanced development will be less likely, because joint campaigning implies in a considerable measure joint planning, the mutual adjustment of plans to the broader needs of the community.

It is true that the present year, 1920, does not seem a propitious one for a large financial "drive" such as this building fund campaign would have to be. There are just two practical recommendations for those who ought to voice the need and lead the campaign to meet it: conviction and courage. There must be profound belief in the urgency of the need for more hospital beds and more dispensaries, and firm determination to meet this need at the earliest possible date.

PROJECTED ENLARGEMENT

The Survey found that a number of Cleveland hospitals had made plans for expansion. Three notable examples are the following:

> The project of Lakeside Hospital to move from its present site near East Twelfth Street and Lakeside Avenue, to Wade Park, enlarging its capacity from 289 beds to 500 beds. In connection with this is to be mentioned the desire to move Maternity Hospital to the same area, and to enlarge it to 100 beds, as a part of the University Hospital group; and, the building of a hospital of 150 beds for babies and children, as part of the same group. The total for the group is 750 beds, making a net increase over present provisions in the same group of institutions of 400 beds.
>
> The project of St. Luke's, to move from its present site on Carnegie Avenue to Ambler Heights, and to enlarge from its present capacity of 139 beds to 300 beds, a net addition of 161 beds, or, if the present hospital were retained and used for an enlarged dispensary and an industrial hospital of perhaps 100 beds, a net addition of about 250 beds.
>
> The project of Huron Road Hospital to move from its present site on Huron Road, to Ansel Road and Wade Park, enlarging its present capacity of 84 beds to 250 beds, a net addition of 166 beds.

The plan of Lutheran Hospital to enlarge from 50 to 100 beds has already been put before the public in a campaign for the needed funds.

A number of other hospitals have stated to the Survey in more or less specific form their desires or projects for expansion. It will be observed that on the minimum basis of calculation the projects of Lakeside, Maternity, the new Babies' and Children's Hospital, Huron Road and St. Luke's would together bring a net increase of 727 beds minimum, or 816 beds maximum. In other words, these projects alone, if carried out, would provide most of the 900 beds which must come from private funds. It is to be desired, however, if a joint campaign for building can be organized and successfully accomplished, that the legitimate desires of some of the small institutions be recognized. It is particularly important that if funds cannot be asked for or secured sufficient to provide for the total amount required for the needs of all the institutions, that some of the smaller hospitals whose present buildings and equipment are now notably inadequate, shall be allotted sufficient amounts to enable them to make needed changes or improvements of a permanent or semi-permanent nature, even if their substantial program of enlargement must be postponed, and if the plans for the three largest hospitals have to be somewhat curtailed. For example, the improvement of the nurses' home at St. Vincent's or the provision of a dispensary at St. John's, are urgently required by present needs for better service, irrespective of increase in the number of beds.

In the rounding out of Cleveland's hospital facilities through the development of specialties, the increase of service to children is the most urgent need in both hospitals and dispensaries. The building of the proposed Babies' and Children's Hospital is perhaps the most greatly needed of Cleveland's hospital facilities, after the enlargement of the City Hospital.

There is need of enlargement of facilities for maternity care, and the program of Maternity Hospital to increase its size from 60 to 100 beds is approved. This, however, is not so urgent as a number of other needs, such as for children's beds, for an eye and ear hospital, or for the improvement in the plants and nurses' homes of several other institutions, such as St. Vincent's, St. Alexis, etc.

In the case of diseases of the eye, ear, nose, and throat, the deficiencies in Cleveland, as pointed out in the early part of this Report, are unusually serious. Many other cities have found it desirable to establish eye and ear hospitals. New York provides 608 beds; Boston, 219; Baltimore, 153; Portland, Maine, 100; Washington, 94; Philadelphia, 58; Pittsburgh, 40; and Chicago, 32. In Cleveland one hospital only (Lakeside) makes any special reservation of beds for eye cases. Six hospitals maintain an ear, nose, and throat service. There is no throat ward in the city. There are cared for in hospitals and dispensaries a relatively small portion of the eye, ear, nose, and throat work required by a population as large as that of Cleveland and its vicinity. No center exists for the training of physicians and nurses in these specialties. There are exceedingly numerous industrial eye injuries. All but one of the twelve oculists who responded to the Survey's letter of

inquiry stated that industrial eye injuries came to them with evidences of having been mishandled.

Of the 545 persons in the city known as totally blind, 306 cases may be considered as due to preventable diseases or injuries. In addition to this number, 121 cases are to be classed as curable.

It is therefore recommended that beds to the number of 100 be established for eye, ear, nose, and throat cases; these beds to be maintained preferably as a branch of an existing general hospital, or, if established as a separate hospital, to be in close cooperation with a general hospital, in order to secure the most economical administration and the mutual advantages of cooperation between the staff of the general hospital and the specialists in eye, ear, nose, and throat. It is essential that there be such freedom and independence for the eye, ear, nose, and throat staff as to enable the fullest development of the special facilities, technic, and educational opportunities, and if these conditions cannot be met were the beds to be part of a general hospital, the beds should be established as a separate hospital, with the affiliation indicated.

It is desirable that the hundred beds be divided between the ear, nose, and throat service, and the eye service, in the proportion of three to two; and that there be maintained a dispensary eye clinic and a dispensary ear, nose, and throat clinic, in connection with these beds. The clinics had best be parts of a general dispensary, but in any case the hospital staff should have direct medical control. It is of course highly important that the eye, ear, nose, and throat beds and clinics be used for medical teaching purposes, under-graduate and post-graduate, and for nurses. It would be well that there be provision among the institutions affiliated with these special beds for an exchange of visiting physicians and surgeons, and of nurses in training.

Provision for all other specialties, such as orthopedics, and laryngology, should be made by the development of services in general hospitals, with an assigned number of beds and with possibly the addition of more beds or pavilions at a future date, rather than by the construction of new important specialized hospitals. The special hospital has a place during the period of development of the technic of a specialty; but the permanent provision of hospital facilities in special branches is better and more economically made by divisions of general hospitals.

Locations and Re-Locations

The study made by the Survey of the locations and inter-relations of hospitals in Cleveland has led to approval of the plans of Lakeside, Huron Road, and St. Luke's hospitals to move from downtown locations to sites in the eastern part of the city, in or near Wade Park. Prevailing winds in Cleveland are from the west, and sites in the eastern part of the city will continue to be dirtier than locations on the western edge, until Cleveland deals effectively with its obnoxious coal smoke. It must be pointed out, however, that the moving-out of these hospitals and the closing of St. Clair

Hospital, which the Survey has recommended, will leave the central portion of the city practically unprovided with local hospital facilities. With adequate ambulance service, such as Cleveland should demand and secure (see discussion of this subject), location will be rendered a secondary factor in a large proportion of hospital cases, yet the tremendous volume of hospital cases arising out of the downtown area cannot but require some local provision.

It will be necessary to retain either at Huron Road or at Lakeside, or in perhaps a new hospital, from thirty to fifty beds, preferably affiliated with a larger out-lying institution so as to secure the advantages of lowered cost and better medical service. It would be more economical if the present site and part of the present buildings of Lakeside or Huron Road were utilized for this purpose instead of requiring new construction.

As outlined in the section on the downtown dispensary, this downtown hospital should be part of the same plant as the new proposed downtown dispensary.

In the chapter on dispensaries and in the chapters just preceding, the need for the development of several additional dispensaries, particularly on the west and south sides was pointed out, and the particular institutions named.

All of these points regarding the location of hospitals and dispensaries and their inter-relation need to be thought out as part of a comprehensive plan for providing general service to the city as a whole, and also local facilities of various kinds, readily accessible to each district. In previous sections of the report it has been brought out that certain of the larger hospitals have a wide range, drawing patients from all over the city and from outside the limits of Cleveland; that other hospitals are largely local in their clientele. The same is true of dispensaries, some being city-wide in their range, others serving few patients outside of one general section of the city, while the health centers are definitely restricted to a certain comparatively small area, as preventive work must be in order to be effective. Certain principles underlying community planning of the number and location of hospitals and dispensaries may be formulated as follows, as the conclusion of this section.

PRINCIPLES OF COMMUNITY PLAN

There should be a small number of what may be called major hospitals and dispensaries, equipped with everything in the way of modern diagnostic and therapeutic equipment. These major hospitals and dispensaries are expected to be city-wide in their range, and to serve particularly for receiving difficult cases from within and outside the city, for consultation purposes and for diagnosis. In Cleveland the new City Hospital with its dispensary should serve as such an institution for the west side. Lakeside, in its present location or in its enlargement as part of the University group, would serve in this capacity also. Mount Sinai and St. Vincent's may be mentioned also, and a few other hospitals, such as St. Luke's, may develop on a similar

grade, although the teaching hospitals and dispensaries should be the distinctive institutions of this class and every effort should be made to render them capable of measuring up to this responsibility fully.

What may be called the district hospital, with its district dispensary or out-patient department, may next be mentioned. In this group may be included the bulk of the hospitals of Cleveland, the range of which is not strictly confined to a given district but which are more local in character and which may not usually expect any large consultant or diagnostic service such as would go with the teaching institutions. Somewhat less elaborate and expensive equipment and a less high degree of specialization in medical organization may be expected in this group of institutions. It may be pointed out that such institutions fill a necessary and most worthy place in the scheme of hospital and dispensary care to the people of large cities.

Finally come the health centers, primarily preventive in their activities. More and more as the years go on, various therapeutic services of the simpler kind need to be located in as many neighborhoods as possible, because the more localized is their range, the more intensively and effectively can they reach 100 per cent. of the population with a message of hygiene, with periodical examinations for the detection and prevention of disease, with service for the prevention of infant and maternal mortality, the discovery and control of tuberculosis, and the detection of remediable physical defects of school children.

The health center should aim to reach the entire population of its district for preventive purposes, sending cases in which defect or disease is discovered, either to the family physician or to an appropriate dispensary or hospital, or in the case of difficult problems, directly to the major institutions for diagnosis. The combination of some of the simpler forms of curative work with the educational and preventive services is a necessary development of the health centers of the future. It may be pointed out that the proposed downtown dispensary and emergency hospital which will be permanently needed in the downtown section after Lakeside and Huron Road move, will be largely a reference center for preventive as well as for diagnostic and curative purposes. Particularly in a city like Cleveland, with its important medical school, the institutions doing the teaching must bear the primary responsibility, in hospitals and in out-patient clinics, for diagnostic service for the patients of private physicians as well as for the patients who cannot afford to pay a physician. The medical profession should reap the benefit of the development of more extensive services in the health centers and in the district hospitals and dispensaries. Appointments therein as staff or auxiliary members and the benefits of their facilities for consultation and diagnosis, should supply the most serious present deficiencies in what the local practitioner has to offer his patients.

It is evident that the danger of a "community plan" is that it leads us to glittering generalities merely. But it ought to be obvious that the absence of a community plan leads to anarchy. Cleveland has taken a long step away from the state of anarchy which characterizes the medical institu-

tions of most large cities, through its Hospital Council and its Welfare Federation. Any community plan which exists not merely on paper but which is a living thing with muscles and teeth, requires that individual institutions must adapt their policies and programs accordingly.

Sacrifices of policies or programs which seem desirable and legitimate from the standpoint of an individual institution may be called for by its proper adjustment to larger community needs. It seems hard, at times, to expect a worthy institution to say "no" to the eager desire of its staff for a program of expansion which a community Survey shows is more than is required by the institution's district or by the particular kind of need which it serves; yet at times such negative prescriptions are wise and necessary, and should be self-imposed. It is not too much to expect of the hospitals and dispensaries of Cleveland that they have a community plan. It is not too much to expect that they abide by it, living not as bachelors and spinsters who have only themselves to consider, but as members of a family each of whom shares, nourishes, and is nourished by the life of the whole.

INDIVIDUAL HOSPITAL PLANNING

The wise planning of a hospital's policy involves at least four elements:

1. Adaptation of the work, as to kinds of service offered, rates charged, etc., to the community, the district and the hospital's special clientele.

This adaptation should be based on knowledge, perhaps requiring special study of the social as well as the medical character of the hospital clientele, as outlined in the section on "The Human Problem of the Hospital Patient". The Cleveland Hospital and Health Survey has rendered to the governing authority of each hospital in the Council a report, the recommendations of which, as to policy and administration, are the result of such a study. Each hospital has thus had a cross section of the situation and demands of 1920, as judged by the Survey.

2. Periodical Self-Surveys, based on continuous critical observation of the institution's work, by its trustees, staff and executive officers, and fortified by annual reports and special studies. As urged below, annual reports should not be the basis for annual self-contemplation, but for a critical review and a vigorous effort toward better service.

3. Long-range planning of program. Each hospital should look as far ahead as possible, studying out its present and future needs, (a) as to kinds of service which it should render and (b) as to the building, equipment, organization, and personnel which it needs to have in order to render these services.

Not a few hospitals of Cleveland are suffering today because no comprehensive plan was made in the past, and additions have been made to hospital buildings which now make a badly balanced plant. Often the service buildings, the nurses' home, or the power plant were not provided for sufficiently when additions were made to bed capacity, or were not planned with a view to easy enlargement when the number of beds should be increased. A comprehensive plan which may be many years in realization will prevent one-sided and ill-judged extensions either in plant or in branches of service. Expert advice and assistance could be provided for many institutions by the Hospital Council or the Welfare Federation in connection with this long range planning of each hospital, although of course in case of large institutions, or where extensive future building plans are involved, the special aid of a hospital architect or consultant may be desirable.

4. Annual Reports to the Welfare Federation and to the Public.

Until recently, each hospital in Cleveland as elsewhere, depended on its own particular list of financial supporters. Each hospital usually prepared its annual report more or less especially designed to express that quality of gratitude which has been described as a "lively expectation of favors yet to come." The situation was radically changed when there came about joint financing through the Community Fund. The individual hospital no longer makes a direct public appeal for its own support. Such joint financing is highly desirable on the whole, but certain minor defects or difficulties must

be guarded against. One of these is a diminished incentive to prepare an annual report. It is true that under such a system as that of the Welfare Federation, each institution must present its budget and the financial and service data required by the Welfare Federation so that the appropriating committee shall be in a position to reach a wise decision. Nevertheless, there is no longer the same sense of direct relationship with the public, and a more or less definite public at that. After all, one of the great values of periodical reports ought to be the stimulus to the people who make them (which mere compilations of financial and statistical data do not provide). Preparation of a report ought to mean the formulation of fairly definite ideas about the work and needs of the matter reported on. It will mean this if the basal scheme of the report is properly designed.

Recognizing this, the Welfare Federation and the Hospital Council should expect their member institutions to render not only the necessary statistical and financial data but also real reports to the public. The future of joint financing depends upon maintaining active public interest in the work to be financed. There must be meat upon which this interest may feed. Concrete facts are the basis.

There should be three types of reports furnished to the public either directly or through the Welfare Federation or the Hospital Council:

1. Summary report of hospital and dispensary work in Cleveland, taken as a whole, including the elementary data showing bulk and general types of service rendered, income and expenses.

This should be prepared under the auspices of the Hospital Council and published by the Welfare Federation. A form for such a report is suggested and may be found in the appendix, Table IX. This may well be compared with the Summary Annual Report of the United Hospital Fund of New York City, the pioneer undertaking of its kind in this country.

2. A report from each hospital to the Hospital Council and the Welfare Federation, giving the technical figures not only of bulk and general types of work but the details of service and results; of cost in relation to units of service: and of income and its various sources.

The monthly and annual report forms prepared by the Hospital Council for the use of its members have served a highly useful purpose. They may be slightly developed further to advantage, and should be made uniform with the reports required by the Welfare Federation. The Hospital Council annual report form is believed to furnish so desirable a basis that no other form will be outlined here. It is suggested that the form might be somewhat smaller and easier to use if some of the items which are extended over many lines were put into more condensed and tabular form. These and other details should be adjusted so far as possible in order that this form shall be comparable with that required by the State Department of Health. Thus the labor of filling out two forms will be reduced to a minimum.

It is recommended that the following items be included in the report form:

Percentage of bed days care given in comparison with total possible number of days care in each division of the hospital, and for the hospital as a whole (monthly and annual.) The extent to which it is possible to subdivide the different sections of the hospital will depend on the degree to which the hospital is itself sub-divided into buildings or separate units, and the degree to which groups of wards or rooms are definitely assigned to particular services or classes of patients.

The number of visits and number of new patients in each clinic or division of the dispensary should be shown as well as the figures for the dispensary as a whole; the average number of visits per patient for each, and the average attendance per clinic day. Thus in tabular form:

CLINIC REPORT FOR MONTH (OR YEAR) FOR DISPENSARY OF.....

Name of Clinic	No. of Visits	No. of New Patients	Av. No. of Visits per Patient	No. of Clinic Days	Av. No. of Visits per Day
Medical					
Surgical					
Pediatric					
Eye					
Dermatological					
Etc.					
Total					

If evening clinics are conducted on a different financial basis (pay clinics) from the corresponding day clinic these should be shown separately.

The cost of the dispensary and the income from its operation in relation to cost should be shown. Income from operation may well be classified into admission fees, treatment fees, fees for medicines.

As soon as the accountant service of the Welfare Federation (as recommended in the sections on administration) is in effective operation, all hospitals would be in a position to show the costs for the main divisions of their work, as well as for the hospital as a whole (average daily per capita) and for the average daily cost for provisions per capita. In so far as it is possible to state relative costs for private room and for ward service, this should be done.

As soon as possible a report on results of service should be developed. The usual report of "condition on discharge" as "cured," "improved", "unimproved", "died", is definite only in the last item; has practically no medical or social value and is not worth including in hospital reports. Real

reports of results of care of patients can develop only as the outcome of a real follow-up system. As individual hospitals develop these, a summary report of results of care should be included in the annual report form. It would be well at once to include the following items in the form under the heading:

"DISPOSITION OF PATIENTS AT DISCHARGE."

Total patients discharged.....

Of these, patients died to the number of.....

Remainder.....

Disposition of these as follows:

	Private Patients		Ward or Staff Patients	
	No.	Per cent.	No.	Per cent.
1. Referred to home under care of private physician.....				
2. Referred to another hospital.....				
3. Referred to convalescent home.....				
4. Referred to dispensary supervision.....				
5. Referred to patient's home without arrangement as to care				
6. Other reference.....				
7. Left against advice.....				
8. Unknown or no record.....				
Total.....				

The use of such data showing administrative action at the time of discharge will be a definite stimulus toward better follow-up and convalescent care.

3. The third form of report from the hospitals should be not statistical but interpretative; a statement of progress and of problems, of accomplishment and of needs.

The traditional annual report has done this in a measure but has often been written by committee members who had little first-hand contact with the facts, or very slight conception of what should be said except thanks to other committee members and to staff and supporters, so that it largely failed to accomplish any real purpose. An annual report should be built from the ground up. The medical executive committee and the head of each main administrative department should be asked to turn in a report

for their several fields six weeks before the report is to be issued. It should be expected that besides certain statistical or other facts relative to the work of the department, these reports shall contain a summary of (*a*) accomplishments of the year—items felt to be indications of progress; (*b*) present problems and needs; (*c*) definite requests and recommendations for action. In some hospitals, each chief of a medical, surgical, or special division, the head of the laboratory, and the head of the X-Ray department will be asked to render reports as well as the medical executive committee.

The reports from the head of the nursing, and from the head of social service, should pass through the training school committee or the social service committee, respectively, before coming to the superintendent and to the trustees. The committee may write its own report if desired, but in any case should state its comment upon the recommendations presented by the executive.

It is recognized that securing reports from many medical and departmental heads is not always easy and that the reports are not always well prepared or to the point. Much of this difficulty has been due to failure on the part of the Superintendent or trustees to give to those writing reports a definite idea as to what was expected.

The superintendent's report to the trustees should be a real survey of the hospital, its accomplishments, problems and needs, and should include recommendations. Trustees who do not receive that type of report either do not know how to get, or do not get, the best out of the man or woman whom they employ as superintendent.

On the basis of such reports from their executive officer and their departments, and of conference with them, the trustees should be in a position to know what they need to know to plan the coming year's policy and program, and the amount of money they need to secure. The reports should be the basis of the presentation of the hospital's needs to the Welfare Federation and should be accessible to those having a basis for definite interest therein.

The trustees ought not to have to prepare a detailed report, but merely a brief statement of decisions or recommendations for which the other reports are the foundation. A group of reports thus prepared should constitute a real annual self-survey. This need rarely be printed as a whole. There is required something less technical for a published report.

INTERPRETING HOSPITAL TO PUBLIC

It is essential from the standpoint of maintaining the interest of the public in a hospital and dispensary and of stimulating boards of trustees of the institution itself, that technical facts of such reports be interpreted in terms of ordinary items of interest and of every-day human standards of health and well-being. This is not usually within the capacity of the hospital administrator or trustee.

The hospital needs, and the Welfare Federation should furnish each hospital, the service of a publicity expert, just as it provides the service of an accountant for the technical data. The publicity man would help the hospital to put its technical facts in common terms, to connect them with ideas and interests which the average man readily understands and appreciates.

The use of such a statement, put into form with the advice of the publicity man, would be partly for those particularly interested in the hospital, and partly for other hospitals and the general public, reached through the Welfare Federation and the press. The custom of presenting reports at an annual public meeting of the trustees or members of the hospital corporation is useful if only that it gives to reports a certain news value.

Under present conditions in Cleveland, the trustees of hospitals are freed from the necessity of the continuous pursuit of the vocation of honorable begging, the most characteristic occupation of trustees in most communities. They may ordinarily concentrate their financial efforts within a brief period of the year, and be free at other times to give their attention to administration, and planning for the hospital. It is above all, important that in working out and planning the present and future policy of individual hospitals, the trustees, the staffs, and the executive officers keep always before them the conception that the hospital is an agent for service to the community, and not an institution with all its roots in its own soil. There is marked danger that those who work within the four walls of an institution lose touch with outside interests and agencies, and develop the ingrowing rather than the outlooking mind. This danger is particularly apparent in such a highly specialized technical service as that of a hospital. A well-managed dispensary tends to assist hospital trustees, staffs, and administrators to keep in touch with the community, because a dispensary is less rigid, less walled-in than a hospital proper, and helps in achieving a practical combination of administrative efficiency with human adaptability. Hospitals closely connected with a church organization appear in some cities particularly prone to be over-institutionalized. The public spirit and community interest manifested by such hospitals as St. Vincent's and St. John's should be mentioned as notable illustrations of a different point of view in Cleveland. Such a cooperative organization as the Cleveland Hospital Council has undoubtedly assisted all hospitals to think in terms of larger units than themselves.

ORGANIZATION TO CARRY OUT PLANS

Planning for individual hospitals and planning for the hospitals and dispensaries of a community as a whole will yield little practical result unless there is community organization of the right sort. In Cleveland we may classify the community functions and organization in two groups, those under public auspices (municipal or state) and those under private auspices, affiliated as members of the Welfare Federation and the Cleveland Hospital Council.

An institution dealing with so serious a matter as treatment of illness has a responsibility to the public which should be recognized by a certain degree of public supervision. By a recent law, the Department of Health of the State of Ohio was empowered to register, define, and classify all hospitals and dispensaries, to require hospital reports, and to license maternity hospitals. It is deemed desirable that these public supervisory powers be extended as follows:

(a) Every hospital and dispensary should be required to obtain a license to operate from the State Department of Health.*

(b) Such license should be issued for a term of one year, renewable by the Department.

(c) Licenses should be revocable for cause, provided that notice of reasons shall be given in advance to the institution and also an opportunity for a public hearing when requested.

(d) Hospitals and dispensaries incorporated as charities should be licensed without fee and a small license fee should be charged to institutions which are incorporated for profit.

(e) Inspection by the State Department of Health should be provided for and appropriation made for a staff to perform this work.

The State Department of Health should be empowered to outline and prescribe requirements or standards under which licenses should be issued and under which hospitals and dispensaries may operate.

The administrative powers of the State Department of Health should be exercised by this Department throughout the State, except in chartered cities. Such cities should be authorized to pass laws or ordinances (the constitution provides that they shall not be inconsistent with the existing state laws) and to administer the licensing and inspecting powers above provided for under its own local authority.

*It is the opinion of Doctor Babcock, who has collaborated on this study, that this is an undesirable administrative responsibility to place on state authorities.

The State Department should administer the law directly in those cities or other political subdivisions which do not maintain their local administration under their own auspices. The State Department of Health should in all cases continue to receive annual reports from hospitals and dispensaries and to maintain a register of all licensed institutions. No chartered city should be permitted to prescribe or tolerate standards for the maintenance or licensing of hospitals or dispensaries which fall below those prescribed by the State Department of Health.

If there were no other reason than the existence in Cleveland of a number of commercial hospitals, this would be sufficient for the extension of the powers of the state and the administration of these powers in Cleveland by the municipal government. The inspection made by the Survey of the sixteen institutions not members of the Cleveland Hospital Council revealed the fact that while a few are of the public-service class and a few others are well conducted proprietary institutions giving a fair standard of care to their patients, the remainder are utterly unworthy of existence. In six cases no graduate nursing service whatever was provided for the sick patients. In more than one instance, the buildings were dirty and the patients appeared to be physically uncared for.

Proprietary hospitals have a legitimate place, but making a profitable business out of the improper care of the sick is intolerable, and can be prevented only by public authority. The State, utilizing as proposed the machinery of the city government in the larger communities, has the right and duty to set minimum standards to which every institution treating the sick shall conform, and to enforce such standards through appropriate agents. Such a policy does not mean interference in hospital management by the state or city, or public regulation of hospitals in any detailed sense of the term. It means the securing of such facts as shall enable the public to be protected against an unworthy and improper class of institution—leaving the majority, which are far above this class, free to conduct themselves as they will.

It is important in a community program for dealing with hospitals and dispensaries, that the municipal agencies caring for the sick shall be properly related to the private agencies, and this has been notably achieved in Cleveland through the Hospital Council. The City Hospital is a member, as well as the privately supported institutions.

The broader interests of the city in public health (in which the hospitals are also concerned) should be brought into closer touch with private agencies interested in such subjects, through some such means as the proposed Cleveland Public Health Association (see Part II.). In the opinion of the Survey, the relations between the Welfare Federation, the Cleveland Hospital Council, and the individual institutions should be somewhat as follows:

OUTLINES OF COMMUNITY ORGANIZATION

1. It is the function of the Welfare Federation to deal with questions of general policies in relation to large groups of welfare agencies and in particu-

lar to provide machinery for joint financing and suitable apportionment of funds raised.

It is highly desirable and has been elsewhere recommended by the Survey (Part II.) that the Welfare Federation have on its executive staff an assistant to its general director, who will be an expert in the health field, and who will be able to advise the director on the many problems in this field to which the Federation devotes over one million of the four million dollars raised annually by the Community Fund.

2. Within the hospital and dispensary field, the Hospital Council should outline standards for hospitals and dispensaries, covering minimum requirements in:

(a) Organization (board of trustees, superintendent, staff, nursing, etc.) for hospitals and dispensaries.

(b) Medical work (examinations, use of laboratories, records, internes, private and ward patients).

(c) Finance and accounting.

3. Only hospitals complying with these standards should be admitted or retained as members of the Council.

4. Only hospitals in the Council should be assisted by the Federation.

5. Financial support by the Federation should be on the basis of charitable work, which should be taken to include free service and also part-pay service, rendered in hospital beds or in dispensary clinics.

6. Appropriations for the support of dispensary work should be separated from those of hospital work, since the units of service are different.

7. Municipal hospitals, and also hospitals not doing charitable work as above defined but complying with the standards, may be members of the Council and the Federation, and receive the benefits of such membership (they will not of course need financial aid).

PLACE OF HOSPITAL COUNCIL

The Cleveland Hospital Council has been of such great value to Cleveland and indeed to the state and the country that too much emphasis cannot be laid upon the importance of its adequate maintenance and development. It has brought the hospitals of the city together for cooperative work, and for mutual improvement in many respects. Advantageous legislation in connection with hospital service and public health work has been promoted by the influence of the Council and by the activities of its executive secretary. Certain of the technical standards, forms of report, etc., as outlined by the Council have been made use of by institutions and by official bodies in other parts of the United States.

The Central Purchasing Department of the Council has been and is a valuable contribution to the economy of hospital administration. The amount of purchasing done (for hospitals alone) for the first half of the year 1919 was $90,890.89; for the entire year of 1919, $268,503.07; and for the first six months of 1920, $222,278.97. It will be noticed that the purchases for the first half of 1920 almost equal the purchases for the entire year of 1919. It is estimated by the Department that there has been a saving on the large purchases for the first half of 1920 to the amount of $10,000.00, and that there was also considerable saving on the small purchases, although no definite estimate can be furnished of this.

Consideration should be given to the transfer of the Purchasing Department from the auspices of the Hospital Council to those of the Welfare Federation, in order that the range of service of the Department may be widened; or the Council might offer the services of the Department to Federation organizations which are not members of the Council.

The opportunities for service by the Council to the hospitals of Cleveland are increasing steadily in proportion as the hospitals appreciate more and more the advantages of cooperative activity in administrative directions, for the sake of economy and efficiency, and of conferences and discussion for more effective formulation of policies concerning hospital service.

The development of a dispensary section of the Hospital Council for purposes of improvement of dispensary service which is recognized as an urgent need throughout the city, is now an important activity which naturally belongs within the general scope of the Cleveland Hospital Council.

Almost endless opportunities exist for service to hospitals through the expert services of the executive staff of the Council, which should assist the members in an advisory way through their own efforts and through assembling information, arranging conferences, securing expert advice from other sources, etc. Many of the recommendations made by the Survey to individual hospitals, particularly those of moderate or small size, will doubtless cause these hospitals to appeal to the Hospital Council for advice in helping them to work out details of such recommendations as are approved in general by the hospital trustees. The interest of the hospitals in legislation will continue to call for some activity in this direction on their part each season.

The organization and staff of the Hospital Council does not appear adequate at present to meet these demands, but it is of the highest importance to the best advancement of hospital and dispensary service in Cleveland that the Council equip itself to carry its increasing responsibilities. It may be noted that the time has probably arrived when a substantial share of the work in initiating and promoting legislation, in which the Council has achieved so much success, may be taken over by the Ohio State Hospital Association. This would seem a logical development.

It is recommended that the proposed Central Dispensary Committee be made part of the activities of the Hospital Council as soon as the Council staff is able to carry the additional work.

HOSPITAL STANDARDS

Membership in the Hospital Council should mean to other hospitals and to the public, the acceptability of the hospital according to standards of good organization and management. The chief present deficiency of the Council is due to the fact that hospitals have been accepted as members whose standards have been too far below those of the average maintained by the Council, and not as high, in one or two institutions, as a few hospitals not members of the Council. It is recognized, however, that in the initial formation of the Cleveland Hospital Council, it was not practicable to define or enforce standards very definitely. The time has now come, however, when definite minimum standards of admission should be publicly known as well as professionally enforced. The Council, through its committees, officers, and executive staff, should be the democratic professional agent of the hospitals and dispensaries, themselves, for their own improvement; and should be the advisor of the Welfare Federation on technical questions concerning hospital and dispensary functions and standards.

The state and city governments, through the regulative acts proposed, should set minimum standards and an institution which does not comply with these should not be allowed to operate at all. Between the minimum standards and the desirable hospital standards is a considerable zone. The Hospital Council should not take in this twilight zone, but should always encourage and assist institutions which are within its shadow to move as rapidly as possible up into the light.

With such relations between the state and city governments, the municipal hospital, the Welfare Federation, and the Cleveland Hospital Council with its hospital and dispensary experts, it is believed there will exist in Cleveland the machinery for the continued advance of hospital and dispensary standards of administration. If such progress is suitably reported to the public through the individual hospitals and through the general activities of the Council and Federation, growing interest and backing for hospital and dispensary work should be annually manifested, expressing itself in more intelligent policies, fuller cooperation, and larger funds for maintenance and for permanent improvement.

But organization after all is only machinery. It is the ideals and spirit of individuals and of small coherent groups working together, which provide the motive power that drives institutions and communities onward. The schemes of organizers, publicity men, and financiers, can make the path easier and lessen friction during the forward movement, but the goal-posts, guides, and impelling forces, for community and institution alike, depend upon the intangible elements of the individual soul and the civic spirit. Cleveland impresses every investigator with its eager readiness for cooperative activity. With such a community spirit, there is indeed the danger that attainment shall be measured too easily in terms of catch-words and externals, and not enough by the more abstract but more fundamental tests

of technic. It is for the development of a high degree of well-founded professional achievement with no loss of its present splendid tradition of community endeavor that every lover of Cleveland must hope.

TABLE I

HOSPITALS AND DISPENSARIES IN CLEVELAND

Institutions Members of Cleveland Hospital Council

	Hospital Beds	Dispensary Visits, 1919
Babies' Dispensary and Hospital—2500 East Thirty-fifth Street	34*	14,977
Cleveland City Hospital—Scranton Road	785	
Cleveland Maternity Hospital—3735 Cedar Ave.	60	3,688
Fairview Park Hospital—3305 Franklin Avenue	85	
Glenville Hospital—701 Parkwood Drive	74	
Grace Hospital—2307 W. Fourteenth Street	35	
Huron Road Hospital—748 Huron Road	84	5,864
Lakeside Hospital—East Twelfth and Lakeside Av.	289	59,891
Lakewood Hospital—14519 Detroit Avenue	53	
Lutheran Hospital—2605 Franklin Avenue	50	
Mount Sinai Hospital—1800 East 105th Street	225	19,324
Provident Hospital—624 East 103rd Street	29	
Rainbow Hospital—South Euclid, Ohio	85	
St. Alexis Hospital—5163 Broadway	250	
St. Ann's Maternity Hospital—3409 Woodland Av.	55	
St. Clair Hospital—4422 St. Clair Avenue	43	
St. John's Hospital—7911 Detroit Avenue	150	
St. Luke's Hospital—6606 Carnegie Avenue	139	13,313
St. Vincent's Charity Hospital— Central and East Twenty-second Street	290	21,863
Warrensville Tuberculosis Sanitarium, Warrensville, Ohio	270	
Woman's Hospital—1948 East 101st Street	37	

*In summer only.

Institutions Not Members of the Cleveland Hospital Council

	Hospital Beds	Dispensary Visits, 1919
†Carnegie Avenue Hospital—8714 Carnegie Avenue	Unknown	
†Class Mineral Fumes Treatments—8101 Hough Ave.	Unknown	
Cleveland Emergency Hospital—1780 East Fifty-fifth Street	22	
Cleveland Home Hospital—5107 Prospect Avenue	10	
†Delmont Hospital and Sanatorium—1770 Delmont Avenue	Unknown	
Dorcas Invalids' Home—1380 Addison Road	46	
East Cleveland Hospital—14420 Euclid Avenue	31	
East Fifty-fifth Street Hospital—2415 East Fifty-fifth Street	60	
East Seventy-ninth Street Hospital—1873 East Seventy-ninth Street	24	
Eliza Jennings Home for Incurables—10603 Detroit Avenue	26	
†Euclid Avenue Hospital and Sanatorium—9810 Euclid Avenue	Unknown	
Florence Crittenden Home—523 Eddy Road	12	
Mrs. Hitchcock's Private Hospital—5013 Prospect Avenue	15	
Holy Cross House—9014 Cedar Avenue	50	
Joanna Private Hospital—933 East Seventy-eighth Street	9	
Kate Castle Rhodes Babies' Dispensary—12611 Madison Avenue, Lakewood		
†Neal Institute Company—3920 Euclid Avenue	Unknown	
†Ohio Sanitariums Company—14822 Terrace Road	Unknown	
†Orthopedic Institute—1936 East Sixty-sixth Street	Unknown	
†Reliable Invalid Home—2222 East Eighty-ninth Street	Unknown	
Rest-Cure Hospital and Sanatorium—2453 East Fifty-fifth Street	16	(in use)
St. Mark's Hospital—629 Eddy Road	45	
Salvation Army Rescue Home—5905 Kinsman Road	54	
U. S. Marine Hospital—1041 Lakeside Avenue	86	4,493
Windsor Sanatorium—4415 Windsor Avenue	38	
Wright's Hospital—18902 Nottingham Road	10	
Y. W. C. A. Retreat—4916 St. Clair Avenue	Temporarily Closed	

†Institutions not reported as registered with the State Department of Health up to June, 1920.

Public Health Dispensaries

Health Center No. 1—1510 East Forty-ninth Street.
Health Center No. 2—502 Central Ave.
Health Center No. 3—2810 Seymour Avenue.
Health Center No. 4—5825 Cable Ave.
Health Center No. 5—9206 Woodland Avenue.
Health Center No. 6—10126 St. Clair Avenue.
Health Center No 7—6100 Pear Avenue.
University Health Center—2739 Orange Avenue.

Prophylactic Baby Stations—

5706 Clark Avenue.
7654 Broadway.
12510 Mayfield Road.
4247 Pearl Road.
833 East 152d Street.
3008 Bridge Avenue.
2511 East Thirty-fifth Street.

Prenatal Clinics—

Maternity Hospital Dispensary—2509 East Thirty-fifth Street.
(Sub-stations)
2749 Woodhill Road.
Alta House, 12510 Mayfield Road.
2317 Lorain Avenue.
Goodrich House, 1420 East Thirty-first Street.
East Forty-ninth and Fleet Street.
Mount Sinai Hospital—1800 East 105th Street
St. Luke's Hospital—6606 Carnegie Avenue.

TABLE II
PERCENTAGE OF OCCUPANCY OF HOSPITAL BEDS

HOSPITAL	Beds* 1919	Per Cent. Occupied 1919	Per Cent. Occupied 1918	Per Cent. Occupied Census Days Averaged
City	785‡‡	60.3	82.2	70.0
Fairview Park	85	60.4	62.3	67.6
Glenville	74	66.3	72.3	69.0
Grace	35	66.8	52.7	94.3
Huron Road	84	75.0	68.2	86.9
Lakeside	289	90.8	82.6	72.9
Lakewood	53	45.9	40.7	68.0
Lutheran	50	80.9	70.5	93.0
Maternity	60*	79.9	70.3	71.7
Mount Sinai	225†	72.4	81.7	84.2
Provident	29	40.5	49.4	65.5‡
St. Alexis	250	78.1	78.0	97.8
St. Ann's	55**	Unknown	75.0	93.7
St. Clair	43	40.2	58.6	33.7
St. John's	150	Unknown	79.0	90.1
St. Luke's	139	75.8	71.6	95.3
St. Vincent's	290	66.9	58.1	73.0
Woman's	37	76.0	Unknown††	Unknown

*For maternity cases, adult beds only were included, except for Maternity Hospital for 1919, which was figured on a basis of 60 mothers and 33 cribs, as the bed days reported included both mothers and babies.

†Mt. Sinai for 1918 was figured on a 155-bed basis; for 1919 on a basis of 155 beds for February and March, and 225 for the remaining ten months.

‡Provident furnished data for the first Survey Census day only.

**St. Ann's figures for 1919 were not furnished.

††No definite information was available regarding beds at Woman's for 1918.

‡‡City was figured on basis of 650 beds until December, 1918, and 785 beds thereafter. Since the field work of the Survey was completed, figures were furnished by the City Hospital Administration, based on 725 beds which were available for 1919, instead of 785. This gives the percentage occupied for the year in the hospital as a whole, as 66.5 per cent. Further details of importance regarding City Hospital will be found in the foot-note, page 834.

TABLE III
HOSPITAL BEDS ACCORDING TO HEALTH DISTRICTS*

District	Type of District	Population of District	Hospitals in District	Total Hospital Beds in District	Beds to 1000 of Population of District (Census I)	Hospital Cases to 1000 of Population of District (Census I)
I	Factory	82,185	Lakeside	429	5.2	2.7
			St. Clair			
			Cleveland Emergency			
II	Factory, Congested	42,159	Huron Road	84	2.0	3.5
III	Near Congested	130,775	City	820	6.3	1.2
			Grace			
IV	Factory, Congested	164,094	St. Alexis	293	1.8	1.2
			East 79th			
			Florence Crittenden			
			Joanna Private			
V	Part Congested	136,294	St. Luke's	280	2.1	1.9
	Part Residential		Holy Cross			
			Salvation Army Rescue Home			
			Woman's			
VI	Industrial	176,836	Glenville	373	2.1	2.1
	Residential		Mount Sinai			
	Congested		Provident			
			St. Mark's			
VII	Semi-congested	90,766	Fairview Park	285	3.1	2.1
	Residential		Lutheran			
			St. John's			
VIII	Congested	72,168	Maternity	490	6.8	4.1
			St. Ann's			
			St. Vincent's			
			East 55th Street			
			Cleveland Home			
			Mrs. Hitchcock's Private			
Outside City Limits			Lakewood	53		
			Rainbow	85		
			Warrensville Tuberculosis Sanatorium	270		
			Wright's	10		
			East Cleveland	31		

*It will be observed that the population figures are those which were furnished the Survey from local estimates, and are higher than those given in the 1920 census. For the sake of uniformity, these estimated population figures have been used throughout this table since its purpose is primarily the comparison of different districts, and census figures for anything except the city as a whole were not available at the time of writing this report.

TABLE IV

PERCENTAGE OF HOSPITAL PATIENTS COMING FROM HEALTH DISTRICT IN WHICH HOSPITAL IS LOCATED

(First Survey Census Day)

Cleveland City	4.6	Mount Sinai	31.2
Cleveland Maternity	13.7	Provident	78.9
Fairview Park	36.7	St. Alexis	35.9
Glenville	46.7	St. Ann's	59.8
Grace	32.3	St. Clair	28.6
Huron Road	6.6	St John's‡	
Lakeside*		St. Luke's	15.6
Lakewood†		St. Vincent's	0.0
Lutheran	44.2	Woman's	26.0

*Address not furnished for 52 per cent. of patients.
†Hospital outside city limits of Cleveland.
‡Address not furnished for 59 per cent. of patients.

TABLE V

PERCENTAGE OF CASES, CLASSIFIED ACCORDING TO COMPENSATION FOR CARE, ADMITTED THROUGH VARIOUS SOURCES TO THREE LARGE GENERAL HOSPITALS

Patients Admitted to Hospital No. I., Classified According to Compensation for Care, and Source of Reference

	Percentage of total admissions	Percentage referred by staff physicians	Percentage referred by non-staff physicians	Percentage referred by by charitable agencies	Percentage not classified	
Patients paying full cost of care	41.9	53.0	43.2	2.2	1.6	100%
Patients paying part of cost of care	20.8	39.3	40.5	20.2	0.0	100%
Patients paying nothing for care	30.1	14.8	45.8	35.7	3.7	100%
Patients not classified	7.2	0.4	34.4	65.2	0.0	100%
	100%					
Percentage of total admissions (excepting patients not classified as to compensation)		37.9	44.3	15.6	2.1	100%

TABLE V—Continued

PERCENTAGE OF CASES, CLASSIFIED ACCORDING TO COMPENSATION, FOR CARE, ADMITTED THROUGH VARIOUS SOURCES TO THREE LARGE GENERAL HOSPITALS

Patients Admitted to Hospital No. II, Classified According to Compensation for Care, and Source of Reference

	Percentage of total admissions	Percentage referred by staff physicians	Percentage referred by non-staff physicians	Percentage referred by charitable agencies	Percentage not classified	
Patients paying full cost of care	27.9	67.5	32.5	0.0	0.0	100%
Patients paying part of cost of care	40.9	68.0	30.9	1.1	0.0	100%
Patients paying nothing for care	15.5	47.7	29.2	20.0	3.1	100%
Patients not classified	15.7	77.3	22.7	0.0	0.0	100%
	100%					
Percentage of total admissions (excepting patients not classified as to compensation)		59.0	35.5	4.2	1.3	100%

Patients Admitted to Hospital No. III, Classified According to Compensation for Care, and Source of Reference

	Percentage of total admissions	Percentage referred by staff physicians	Percentage referred by non-staff physicians	Percentage referred by charitable agencies	Percentage not classified	
Patients paying full cost of care	30.5	56.4	43.6	0.0	0.0	100%
Patients paying part of cost of care	49.3	50.0	50.0	0.0	0.0	100%
Patients paying nothing for care	20.2	73.5	26.5	0.0	0.0	100%
Patients not classified	0.0	0.0	0.0	0.0	0.0	0.0
	100%					
Percentage of total admissions (excepting patients not classified as to compensation)		68.9	31.1	0.0	0.0	

TABLE VI

FINANCES OF HOSPITALS IN CLEVELAND HOSPITAL COUNCIL, 1919

Municipal

	Total Expense for Hospital	Total Earnings from Operation	Percentage Expenses are of Total Earnings
Cleveland City Hospital	$428,636.77		
Warrensville Tuberculosis Sanatorium	197,020.15		
Total Municipal	$625,656.92		

Non-Municipal

*Babies' Dispensary	67,305	$ 7,000	10.4%
*Cleveland Maternity	90,435	58,802	65.0
*Fairview Park	85,000	65,000	76.5
‡Glenville	.....	.....	.....
*Grace	33,000	33,000	100.0
*Huron Road	117,600	83,800	71.3
*Lakeside	480,000	264,000	55.0
*Lakewood	58,000	52,000	89.7
‡Lutheran	.....	.....	.....
†Mount Sinai	332,000	200,000	60.4
*Provident	14,000	13,000	92.9
*Rainbow	63,445	12,910	20.4
*St. Alexis	108,800	70,000	64.3
*St. Ann's	107,125	84,888	79.2
*St. Clair	36,975	28,390	76.7
*St. John's	169,342	120,200	70.9
*St. Luke's	207,120	176,820	85.4
*St. Vincent's	249,350	204,800	82.1
*Woman's	50,083	39,600	79.2
Total Non-Municipal	$2,269,580.00		
Grand Total	$2,895,236.92	$1,514,210	

Summary for Non-Municipal Hospitals (so far as calculable)

Subtotal, Expense for Hospitals	$1,927,993.00
Subtotal, Earnings from Operation	1,296,214.00
Bed Days Care, 1919	439,700
Average Cost per Day of Care	$4.39
Average Earnings per Day of Care	$2.95
Percentage of Average Cost per Day of Care Earned from Operation	67.2

*Budget for these institutions covers the year from October 1, 1919, to September 30, 1920.
†Budget for this institution covers the year from January 1, 1920, to December 31, 1920.
‡In order to estimate the average cost and average earnings per day of care for non-municipal hospitals, it is necessary to omit the following hospitals from the calculation: Glenville and Lutheran, as at the time of preparing the table, the total cost and total earnings of these institutions for 1919 could not be ascertained; and also Rainbow, St. Ann's, and St. John's, as at the time of preparing the table, the number of bed days care for the year 1919 could not be ascertained. The figures in the summary therefore do not make a total as large as in the non-municipal group in the table.

TABLE VII

SUMMARY OF CONVALESCENT CASES

Cases with Home Environment	Charity Cases.	Charity Per ct.	City Cases.	City Per ct.	Lakeside Cases.	Lakeside Per ct.	Mt. Sinai Cases	Mt. Sinai Per ct.
Favorable and Adequate	15	30.0	5	7.0	4	7.0	1	4.5
Favorable with minor adjustments	21	42.0	19	26.8	21	36.8	10	45.5
Unfavorable but remediable	6	12.0	21	29.6	14	24.6	7	31.8
Unfavorable and not remediable	6	12.0	20	28.2	16	28.1	2	9.1
Acutely needing further hospital care	2	4.0	6	8.4	2	3.5	2	9.1
	50	100.0	71	100.0	57	100.0	22	100.0

Cases with Home Environment	Total cases	Total Per ct.
Favorable and Adequate	25	12.5
Favorable with minor adjustments	71	35.5
Unfavorable but remediable	48	24.0
Unfavorable and not remediable	44	22.0
Acutely needing further hospital care	12	6.0
	200	100.0

TABLE VIII

PATIENTS REMAINING IN HOSPITAL OVER TWO MONTHS

HOSPITAL	Number of patients on Survey census days, averaged	Number of patients remaining over two months on census days, averaged	Percentage of patients remaining over two months on census days, averaged
Cleveland City	549.5	162.5	29.6%
Cleveland Maternity	43.0	0.0	0.0
Fairview Park	57.5	2.5	4.3
Glenville	51.0	1.0	2.0
Grace	33.0	2.0	0.6
Huron Road	73.0	6.5	8.9
Lakeside	215.5	26.0	12.1
Lakewood	36.0	3.0	8.3
Lutheran	46.5	0.5	0.1
Mt. Sinai	160.0	8.0	5.0
Provident	19.0*	0.0	0.0
St. Alexis	244.5	22.5	9.2
St. Ann's	51.5	0.5	0.9
St. Clair	14.5	1.0	6.9
St. John's	137.0	9.5	6.9
St. Luke's	132.5	4.5	3.4
St. Vincent's	210.0	15.0	7.1
Woman's	43.0	0.0	0.0
Totals	2,117.0	265.0	7.9

*Information was received from Provident Hospital for the first Survey census day only.

TABLE IX.

PROPOSED FORM FOR SHOWING HOSPITAL AND DISPENSARY SERVICE OF CLEVELAND

As Rendered by the Members of the Cleveland Hospital Council During 19.....

	Name of Hospital	Name of Hospital	Total for Cleveland Hospital Council
Hospital—			
Number of Beds			
Total Hospital Days Care			
Percentage of Possible Days Care			
Classes of Patients			
Pay Patients			
Number			
Days Care			
Part-pay Patients			
Number			
Days Care			
Free Patients			
Number			
Days Care			
Percentages of Days Care			
Pay			
Part-pay			
Free			
Equivalent Free Days			
Sex and Age of Patients			
Men			
Women			
Children under 15			
Average Days Stay per Patient			
Total Number of Patients			
Income			
From Operation			
From Endowment			
From Community Fund			
From Other Sources			
Percentage from Operation			
Percentage from Community Fund			
Expenditures			
Total for Hospital			
Average per Days Care			
Average per Day for Food Only			
Dispensary			
Total Visits			
New Patients			
Men			
Women			
Children under 15			
Total			
Average Visits per Day			

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List of Parts and Titles

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